KENTUCKY MEDICAID PROGRAM
NURSING FACILITY SERVICES MANUAL

SECTION V – SCOPE OF SERVICES

SECTION V - SCOPE OF SERVICES

V. SCOPE OF SERVICES

A. Nature

Benefits shall be financial reimbursement for authorized services that were provided. Reimbursement shall be made directly to participating providers. All payments shall be made to the nursing facility for services provided to Medicaid residents with the exception of reimbursement for Medicaid covered drugs and insulin syringes which shall be made to the Medicaid participating pharmacy under contract to the nursing facility to provide drugs for the facility's residents.

Payment of a zero ("0") amount is considered as a payment by the Medicaid Program.

A zero payment is not to be interpreted as a non-payment.

B. Initiation

Provider payments shall begin upon admission of an eligible resident to a participating nursing facility, provided such benefit provision has been authorized by the PRO and admission is to a nursing facility participating in the Medicaid Program, authorized by the Department for Medicaid Services.

C. Duration

Provider payments shall continue until the resident is discharged, expires, or until authorization for benefit provision is withdrawn by the PRO, and if residency is in a nursing facility participating in the Medicaid Program authorization is withdrawn by the Department of Medicaid Services, on the basis of medical data indicating an alleviation of needs for nursing facility services as defined by the Medicaid Program.

D. Case-Mix

Medicaid makes reimbursement to nursing facilities for routine services they provide plus ancillaries (other than brain injury programs and specially certified ventilator facilities which have all-inclusive rates). A nursing facility's Medicaid routine per diem rate, unless otherwise specified, is established by Medicaid based on a

prospective Case-Mix Assessment Reimbursement System which is fully described in the regulation 907 KAR 1:065.

The prospective Case Mix Assessment Reimbursement system is designed to achieve three major objectives:

1. To assure that needed nursing facility care is available for all eligible residents including those with higher care needs.

2. To provide an equitable basis for both urban and rural facilities to participate in the Program, and

3. To assure Program control and cost containment consistent with the public interest and the required level of care.

E. Medical Prior-Authorization Procedure for Medicaid

The PRO shall be responsible for determining if nursing facility level of care is met for all nursing facility services for Medicaid residents as described in Section IV of this manual. PRO staff shall review prospective admissions when contacted by telephone at 1-800-292-2392. Nursing facility level of care shall be reevaluated by PRO staff during on-site visits.

When a Medicaid applicant or resident has been certified by the PRO as meeting the criteria for nursing facility care, a copy of the Confirmation Notice shall be sent by the PRO to the local office of the Department for Community Based Services.

F. Covered Services

Reimbursement by Medicaid represents payment-in-full for Medicaid covered services provided to Medicaid residents who have been determined by the PRO to meet the criteria for nursing facility placement. Any item covered by Medicaid for a nursing facility shall be prescribed by a physician and necessary for the habilitation or rehabilitation of the Medicaid resident so that he can function at his maximum level. Medicare (Title XVIII) has first liability for coverage of items for residents who are QMB only, dually eligible and Medicare and Medicaid non-QMB eligibles. The Medicaid Program shall only be responsible for any applicable Medicare deductible or coinsurance amounts in these instances.

SECTION V - SCOPE OF SERVICES

The Medicaid Program shall only make reimbursement for services that are medically necessary and ordered by the attending physician.

If the facility receives payment from an eligible Medicaid resident for a covered service, Medicaid Program regulations require that the payment be refunded PRIOR TO BILLING the Medicaid Program. This policy shall not apply to payments made by residents for non-covered items or services.

All items and services considered by the Medicaid Program to be non-covered, that were provided to Medicaid residents during any period of a covered stay, may be billed to the resident or another payer. The amounts covering these items shall not be listed as an amount received from other sources when billing the Medicaid Program.

The charge made to the Medicaid Program shall be the same charge made for comparable services and items provided to any party or payer. A covered service or item shall be reimbursed only one (I) time. Any duplication of payment by the Medicaid Program, whether due to erroneous billing or payment system faults, shall be refunded to the Medicaid Program. Failure to refund a duplicate or inappropriate payment may be interpreted as fraud and abuse, and prosecuted as such.

1. Routine Services

   Covered routine services include room, dietary services, social services, nursing services, the use of equipment and facilities, and medical and surgical supplies.

   (a) Private Room

      (1) If the attending physician orders a private room for the resident, the facility shall not charge the family or responsible party any difference in private and semi-private room charges. The facility enters their charges for a private room when billing the Medicaid Program.

      (2) If the only available Kentucky Medicaid certified bed in the facility is in a private room, and the attending physician did not order a private room, the facility may:

a) Make arrangements with the family or responsible party (but not the resident) to pay the difference between the facility's CHARGES for a private room and their CHARGES for a semi-private room,

OR

b) Decline to charge the family or responsible party for any difference in private and semi-private room charges. If the facility elects the first option, the facility shall submit their charges to the Kentucky Medicaid Program for a semi-private room. If the facility elects the second option, the facility shall submit their charges for a private room.

(3) If the family or responsible party requests the private room, and the attending physician did not order a private room, the facility shall make arrangements with the family or responsible party (but not the resident) to pay the difference in the facility's private and semi-private room CHARGES. Under these circumstances, the facility shall only enter their charges for a semi-private room when billing the Medicaid Program. This is regardless of whether or not the family or responsible party paid the difference in private and semi-private room charges.

(4) If the recipient chooses a private room, and the attending physician did not order a private room, the facility may make arrangements with the resident to pay the difference in the facility's private and semi-private room charges. THIS IS THE ONLY CIRCUMSTANCE UNDER WHICH THE RESIDENT SHALL BE CHARGED.THE DIFFERENCE IN PRIVATE AND SEMI-PRIVATE ROOM CHARGES.

The facility may only enter their charges for a semi-private room when billing the Medicaid Program. This is regardless of whether the resident paid the difference in the facility's private and semi-private room charges.

(b) Podiatry Services

The cost of podiatry services, when ordered by the attending physician, shall be allowable under the routine aspect of the case-mix reimbursement system for Medicaid-only residents. Podiatrists shall not independently bill the Medicaid Program for services provided to Medicaid-only residents in provider payment status in a nursing facility. Payment to the podiatrist for the Medicaid-only resident shall be through a contractual arrangement between the facility and the podiatrist. For the QMB only, dual eligible and Medicare and Medicaid (non-QMB) residents, Medicare has first liability. The podiatrist, if enrolled in the Medicaid Program, may bill the Medicaid Program for Medicare deductible and coinsurance amounts. If the podiatrist is not enrolled in the Medicaid Program or does not choose to bill the Medicaid Program, the nursing facility may bill Medicare deductible and coinsurance amounts to Medicaid on the UB-92 billing form.

(c) Prosthetic Devices

Prosthetic devices which are necessary for the rehabilitation of the Medicaid resident so that he or she can function at a maximum level should be provided to the Medicaid recipient residing in a nursing facility, if it has been ordered by a physician and is medically and functionally necessary for the treatment of an illness or injury. Prosthetic devices, such as artificial limbs and braces, is allowable under the routine aspect of the case-mix reimbursement system. Medicare (Title XVIII) Part B has first liability for coverage of such items for the QMB only resident, the dual eligible resident, and the resident eligible for both Medicare and Medicaid non-QMB.

The procurement and provision of these devices is included in the calculated nursing facility's routine reimbursement rate. Some prosthetic devices may be reimbursed by other sections of the Medicaid program. For example, dentures, lenses and frames, hearing aids, pacemeakers, etc.

The purchase of orthopedic shoes shall be allowable under routine reimbursement ONLY if the shoe is affixed to and is an essential part of the orthotic device.

(d) Durable Medical Equipment

The Medicaid Program shall not make reimbursement to durable medical equipment (DME) providers for services and items provided to the nursing facility resident other than Medicare deductible and coinsurance amounts.

(e) Laundry

Nursing facilities shall launder institutional gowns, robes and personal clothing which are the normal wearing apparel in the facility without charge to the resident or his family or responsible party. If the family or responsible party CHOOSES, they (family or responsible party) can pay for laundry charges or accept responsibility for the laundry. It shall clearly be the choice of the family or responsible party and not a condition of admission or continued stay. If the family or responsible party does not choose to pay for laundry charges or to launder the clothing, the facility shall provide the service as a part of routine cost.

The facility shall advise the family or responsible party of all options regarding laundering of personal clothing including the fact that if they (family or responsible party) chooses not to pay for laundry charges or launder the clothing, the facility shall provider the service without charge to them (family or responsible party) or the resident.

The facility shall separate personal laundry from the facility's soiled linens and diapers to achieve cleanliness and to ensure that the clothing is not damaged. Reasonable efforts shall be taken to assure that resident's laundry is done properly, even if that requires special handling.

2. Ancillary Services

Ancillary services are those for which a separate charge is customarily made. Ancillary services include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, oxygen and other related supplies.

(a) Therapy

907 KAR 1:023, Review and Approval of selected therapies as ancillary services in Nursing Facilities, provides for the conditions under which oxygen and therapies meet the criteria for payment as ancillary services.

(b) Dietary Supplements

Enteral food supplements used for tube feeding or oral feeding, even if written as a prescription item by a physician, and the supplies related to their administration shall be considered allowable routine costs. If covered by Medicare, Medicaid shall make reimbursement for any Medicare deductible and coinsurance amounts when appropriately billed to Medicaid by the actual provider of the service or item, if that provider is enrolled in Kentucky Medicaid, or to the nursing facility but not by both. Hyperalimentation is considered a drug and therefore billable to Medicaid by the pharmacy.

(c) Laboratory Services

Coverage of laboratory procedures for Kentucky Medicaid participating independent laboratories include procedures for which the laboratory is certified by Medicare.

G. Pharmacy Services

1. General Pharmacy services shall be provided through a contractual arrangement between the nursing facility and a pharmacy that is enrolled, or will enroll, in the Medicaid Program. Payment for Medicaid covered drugs and insulin syringes shall be made to the Medicaid participating pharmacy.

Payment shall not be made for those drugs determined to be less than effective by the Food and Drug Administration (FDA). This includes all drugs listed on the Drug Efficacy Implementation Study (DESSI) and Identical, Related and Similar (IRS) drug lists. Notification of these drugs is periodically distributed to Medicaid participating pharmacies and nursing facilities. Also, for drugs provided on or after May 1, 1991, a payment shall not be made for those labelers who have not signed a rebate agreement with the federal government.

2. Medicaid Request Form for Drugs Prior-Authorized for Nursing Facility Residents (MAP-573)

A broader range of drugs is covered by Medicaid for the resident in Medicaid long term care vendor payment status in a nursing facility than for those recipients in their own home setting. In order for the pharmacy to appropriately bill Medicaid, the nursing facility shall advise the pharmacy of both the admission and permanent discharge of the Medicaid and Medicaid-pending resident.

To provide access to these drugs, the nursing facility shall initiate an MAP-573 form for all admissions for which Medicaid will be the primary payer and forward it to their

pharmacy. The MAP-573 shall not be initiated for residents with both Medicare and Medicaid for whom Medicare is the primary payer or for the Medicaid eligible residents in private pay status.

H. Transportation Services

Medicaid shall cover transportation to and from Medicaid Program covered medical services by ambulance or other approved vehicle if the resident's condition requires special transportation. Also covered shall be pre-authorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services when provided by a participating medical transportation provider. Travel to pharmacies shall not be covered.

I. Vision Services

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists shall be covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs shall be covered for eligible recipients under age twenty-one (21).

J. Benefits Available to Residents Under Title XVIII

Dually eligible residents and residents eligible for both Medicare and Medicaid (non-QMB) shall be required to EXHAUST any applicable benefits under Title XVIII (Part A and Part B) prior to coverage under the Medicaid Program.

1. Part A Benefits

Medicare Part A coinsurance amounts shall be billed to Medicaid by the nursing facility.

2. Part B Benefits

Medicare Part B deductible and coinsurance amounts may be billed to Medicaid by the nursing facility or the actual provider of the Part B service if that provider is enrolled in the Medicaid Program, but not by both. Examples of services that might be covered under Medicare Part B are x-ray, laboratory, physical therapy and occupational therapy.

SECTION V - SCOPE OF SERVICES

K. The Notice of Availability of Income for Long Term Care/Waiver Agency/Hospice (MAP-552)

The MAP-552 advises the nursing facility of the monthly amount of income the resident is responsible for paying the facility toward his cost of care. The facility shall not collect a patient liability amount from the resident who is QMB only.

For dually eligible residents who are admitted to a nursing facility under Title XVIII (Part A) and for whom Medicare coinsurance will be billed to the Medicaid Program, the local Department for Community Based Services (DCBS) initiates action on the MAP-552 when they have received a Memorandum (MAP-24) from the nursing facility, Medicaid, other insurance, notifying DCBS of the admission.

For Medicaid only applicants or residents, DCBS initiates action on the MAP-552 when they have received a Confirmation Notice from the PRO.

When there is a change in the amount of the continuing income received by the resident (either an increase or a decrease), a MAP-552 shall be prepared by the DCBS worker. Income data entered on the MAP-552 for that admission shall remain in effect until a new MAP-552 is issued.

The resident's income shall be disregarded through the month of admission when initially admitted to a nursing facility. The continuing income as indicated on the MAP-552 is to be collected by the facility from the resident or responsible party, e.g., family, guardian, or conservator. A direct transfer to another nursing facility would not begin another period of income disregard. If the resident is out of provider payment status for thirty (30) days or more, DCBS shall allow a new income disregard period. The Medicaid Program disregards the income for the month of admissions (EXCEPT for individuals covered under a Veterans Administration contract, commercial health insurance or private pay) but considers it only for any other subsequent month. The Medicaid Program also disregards the income for the month of admission when the individual transfers to a nursing facility from a personal care facility or from a family care facility.

Claims processed prior to entry into the system of continuing income data will reject; therefore, it is recommended that initial claims be submitted only after the MAP-552 is received by the nursing facility.

Continuing income, if any, is to be collected when billing Medicaid for in-house days, bed reservation days, and Medicare Part A coinsurance days.

If a partial month of services is provided, the total amount of a resident's available income is not to be collected. The computer automatically prorates the resident's available income and deducts that portion of the income available for collection of a partial month of services. The following formula shall be used.

Days of service x resident's available income - days in month = amount to be collected from the resident or APPLICABLE INCOME for that portion of the month.

For example: 10 days x $110.00 divided by 30 days in month = $36.67

L. Memorandum to Local DCBS Office (MAP-24)

The MAP-24 shall be submitted by the nursing facility to the local DCBS office to report the following information, within ten (10) days of its occurrence:

1. Admission of a dually eligible resident for whom Medicare Part A is the primary payer. A MAP-24 shall not be submitted for the QMB-only resident.

2. Discharge or death of any Medicaid resident.

3. The date a Medicaid resident is accepted for hospice coverage. (To be reported as a discharge from the nursing facility even if the resident shall remain in the facility.)

This information allows the DCBS office to generate an MAP-552 for the dually eligible resident for whom Medicare is the primary payer. This flow of information is essential to timely payment to the nursing facility and efficient records for DCBS.

M. Days

1. For Medicaid purposes, a day shall be considered in relation to the midnight census.

2. Medicaid shall pay for the date of admission but shall not pay for the date of discharge (death).

3. Ancillary charges incurred on the date of discharge (death) shall be Medicaid covered.

4. Neither the resident nor his family or responsible party shall be billed for the date of discharge.

5. Early admission fees or late discharge fees shall not be billed to Medicaid or charged to the resident or his or her family or responsible party.

N. Bed Reservation Policy

The Medicaid Program shall make payment to a nursing facility during a Medicaid resident's absence for acute care hospitalization and therapeutic home visits provided certain criteria are met. Bed reservation days shall not be available for the resident admitted to a mental hospital.

Facilities shall allow residents for whom Medicaid is paying to reserve a bed, return to that bed when they are ready for discharge from the hospital or when returning from therapeutic home visits, regardless of the day of the week (this includes holidays and weekends.)

If the facility chooses not to reserve a bed for a resident for whom bed reservation days are available, the facility shall advise the resident prior to his or her departure from the facility.

It shall be the responsibility of the nursing facility to assure that services and items ordered by a resident's physician are provided while the resident is out of the facility (other than for hospitalization) and Medicaid will be billed to reserve the bed. The nursing facility shall not be responsible if the resident was on bed reservation days for hospitalization as the hospital would be providing required

services and items. If the nursing facility cannot provide the required ancillaries directly, the facility shall make arrangements with a qualified source (i.e., pharmacy, physical therapist, speech therapist, etc.) for the resident to obtain the required services and items. Pharmacies shall bill Medicaid directly; therapists, etc. shall bill the facility. As always, if the resident receives an ancillary service or item that Medicare Part B can cover, the nursing facility shall ensure that the Title XVIII carrier is billed prior to seeking reimbursement from Medicaid.

1. Criteria for approved bed reservation shall be:

   (a) The resident is in Medicaid long term care vendor payment status and has been a resident of the facility at least overnight. Persons for whom Medicaid is making Title XVIII Part A coinsurance payments shall not be considered to be in Medicaid payment status for purposes of this policy.

   (b) The resident is reasonably expected to return to the same facility with Medicaid as the primary payer. If returning to the same facility with Medicare as the primary payer, bed reservation days shall only be available up to the day Medicare eligibility is determined, provided the bed reservation day maximums are not exceeded.

   (c) Due to a demand for beds at the facility, there is a likelihood that the bed would be occupied by some other resident were it not reserved.

   (d) The hospitalization shall be in an acute care hospital or a Kentucky hospital certified by Kentucky to participate in the acute care hospital program. The hospitalization shall be approved by the PRO.

   (e) If hospitalization is approved, and the bed occupied by the resident is also a Medicaid certified acute care bed, the resident shall have been transferred to a specialty unit of a hospital.

   (f) For therapeutic home visits, the resident's physician orders and plan of care provide for these leaves. Therapeutic home visits include visits with relatives and friends.

2. Medicaid payment for bed reservation days shall be limited as follows:

   (a) A maximum of fourteen (14) days per calendar year due to an acute care hospital stay.

   (b) A maximum of ten (10) days per calendar year for leaves of absence other than hospitalization.

   (c) Reimbursement shall be seventy-five (75) percent of a facility's rate if the facility has an occupancy percentage of ninety-five (95) percent or higher.

   (d) Reimbursement shall be fifty (50) percent of a facility's rate if the facility has an occupancy percentage lower than ninety-five (95) percent.

   Maximums are applied per provider number. For billing purposes, one (1) nursing facility shall not be concerned with bed reservation days the resident may have used at another nursing facility.

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APPENDIX I – MAID CARDS

MAID CARDS

MAID CARDS

Medical Assistance Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month—to—month eligibility period. Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend down" case receive one MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend down" eligibility period.

MAID CARDS shall show a retroactive period of eligibility. Depending on the individual circumstances of eligibility, the retroactive period shall include several months.

Duplicate MAID cards shall be issued for individuals whose original card is lost or stolen. The recipient shall report the lost or stolen card to the local Department for Community-Based Services, Division of Field Services worker responsible for the case.

VERIFYING ELIGIBILITY

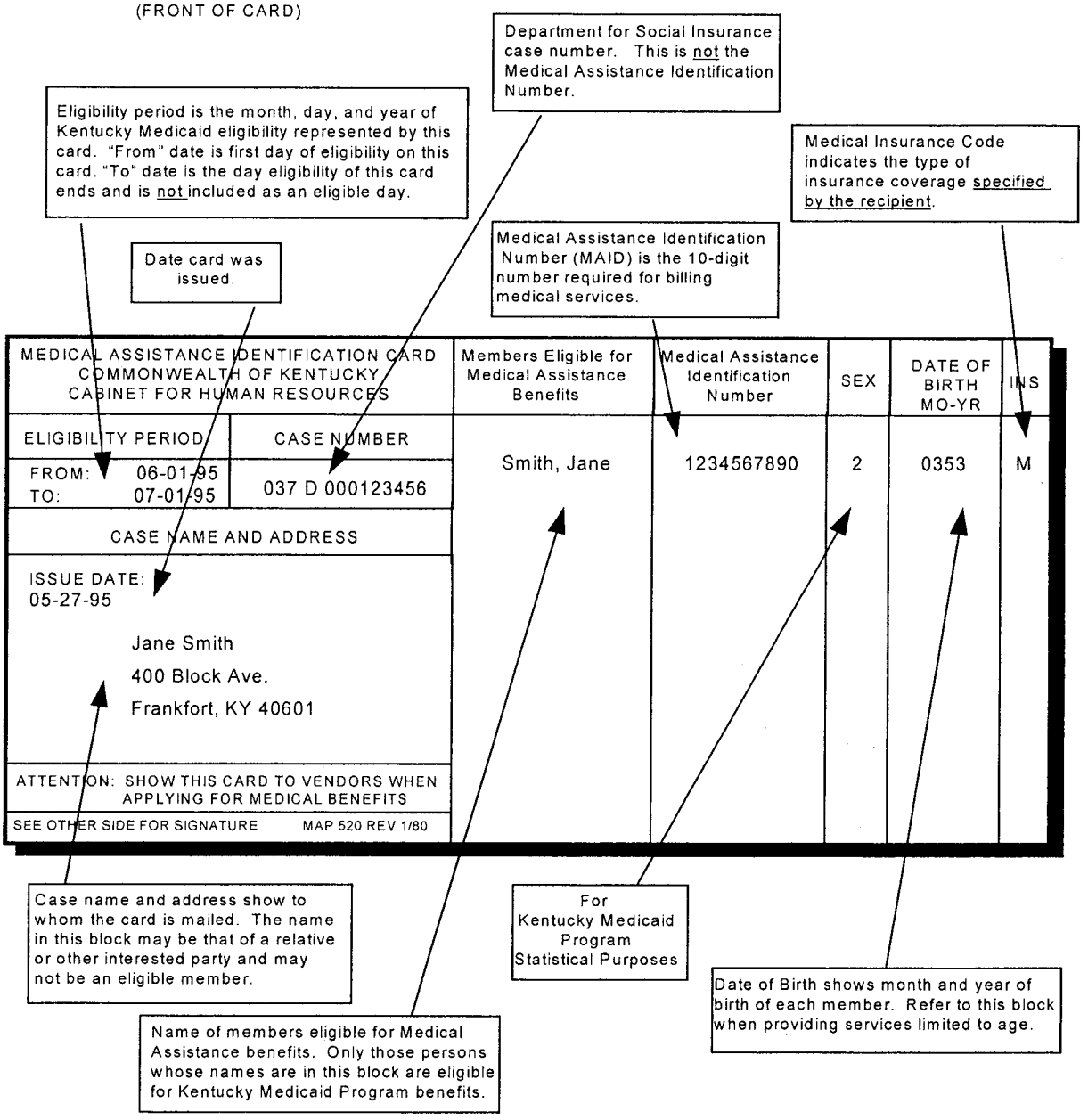
The local Department for Community-Based Services, Division of Field Services staff shall provide eligibility information to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564—6885 shall also verify eligibility for providers.

1.1. KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (MAID) CARDS

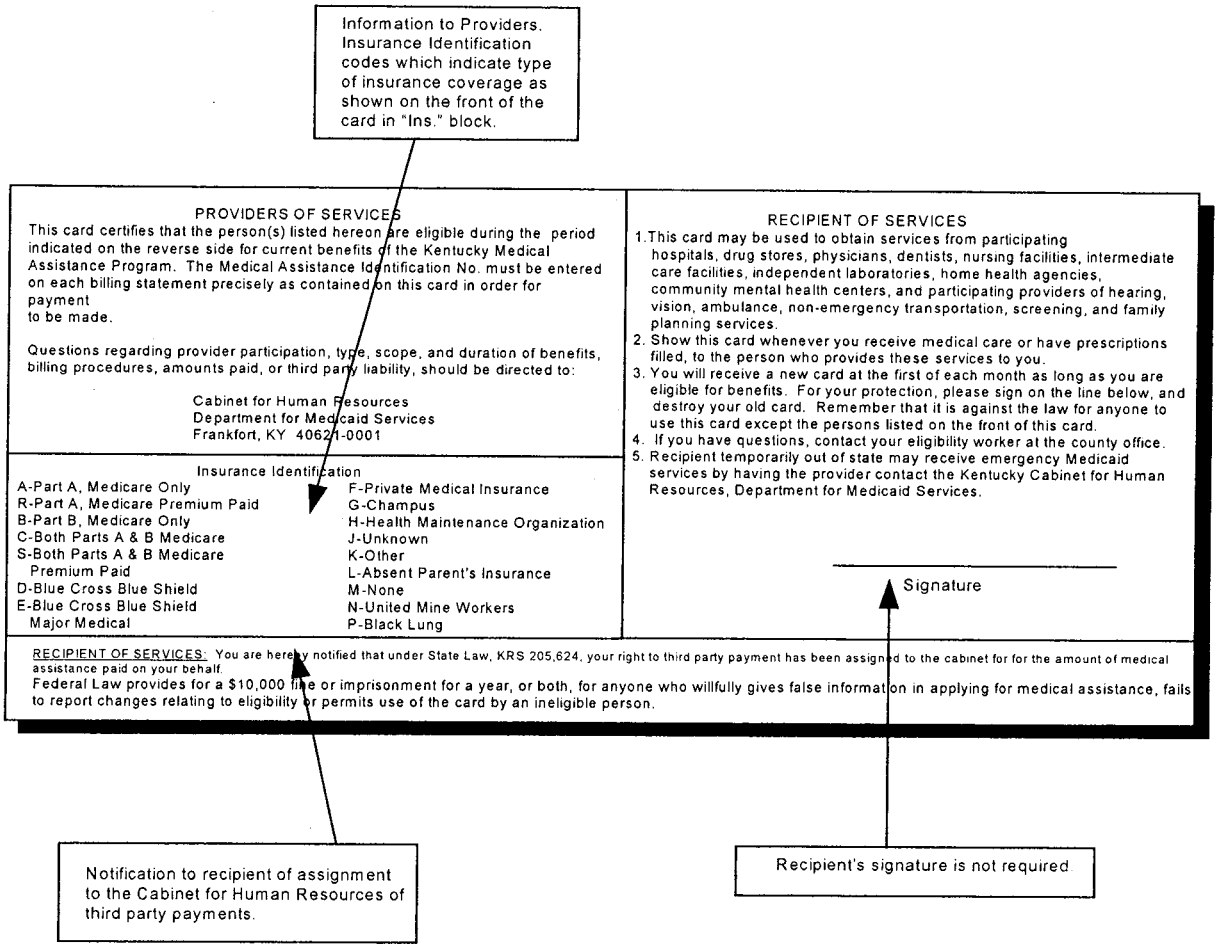
1.1.1. REGULAR MAID CARD

(FRONT OF CARD)

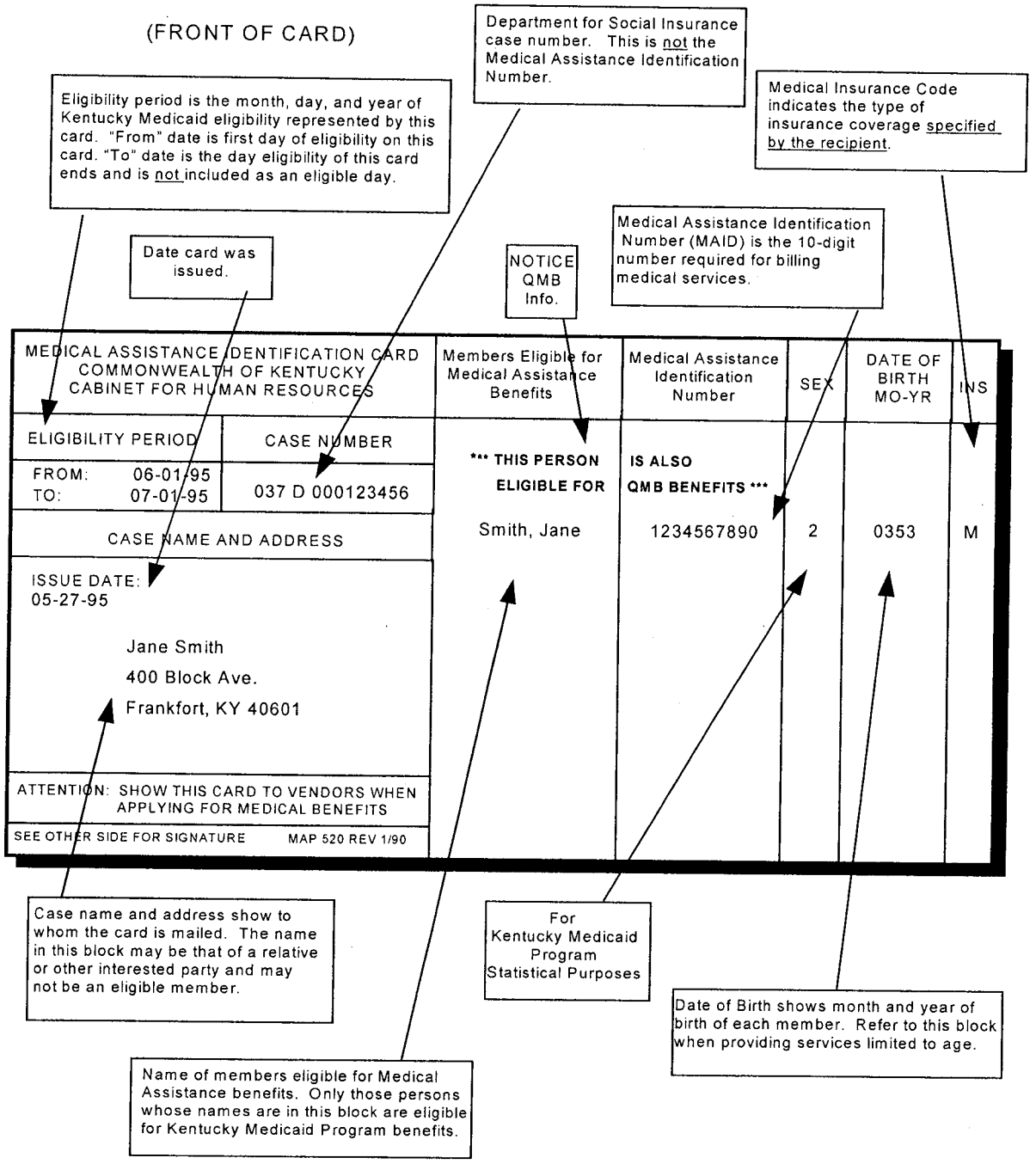


WHITE CARD

BACK OF MAID CARD

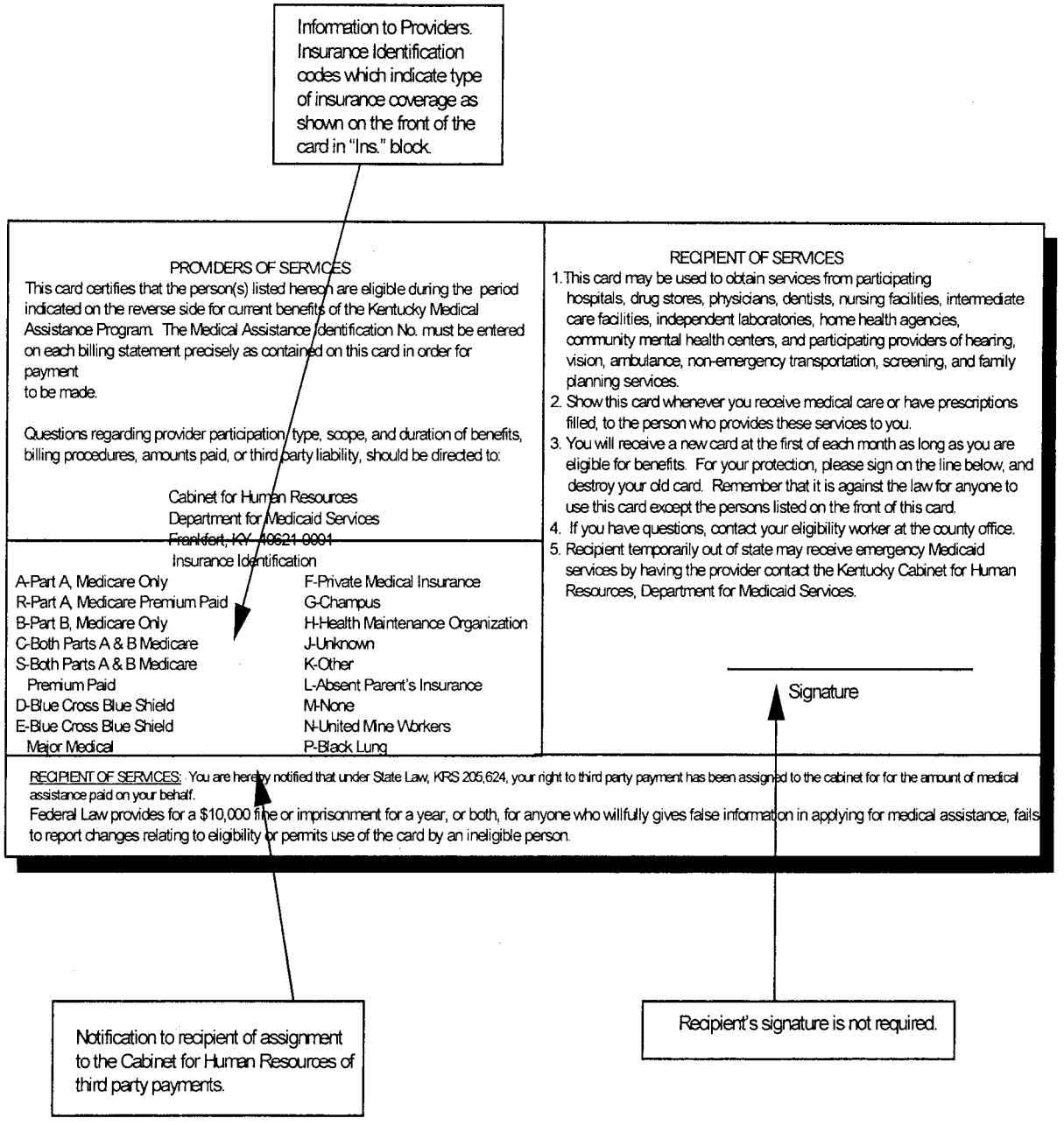


1.1.2. QUALIFIED MEDICARE BENEFICIARY (QMB)/MAID CARD

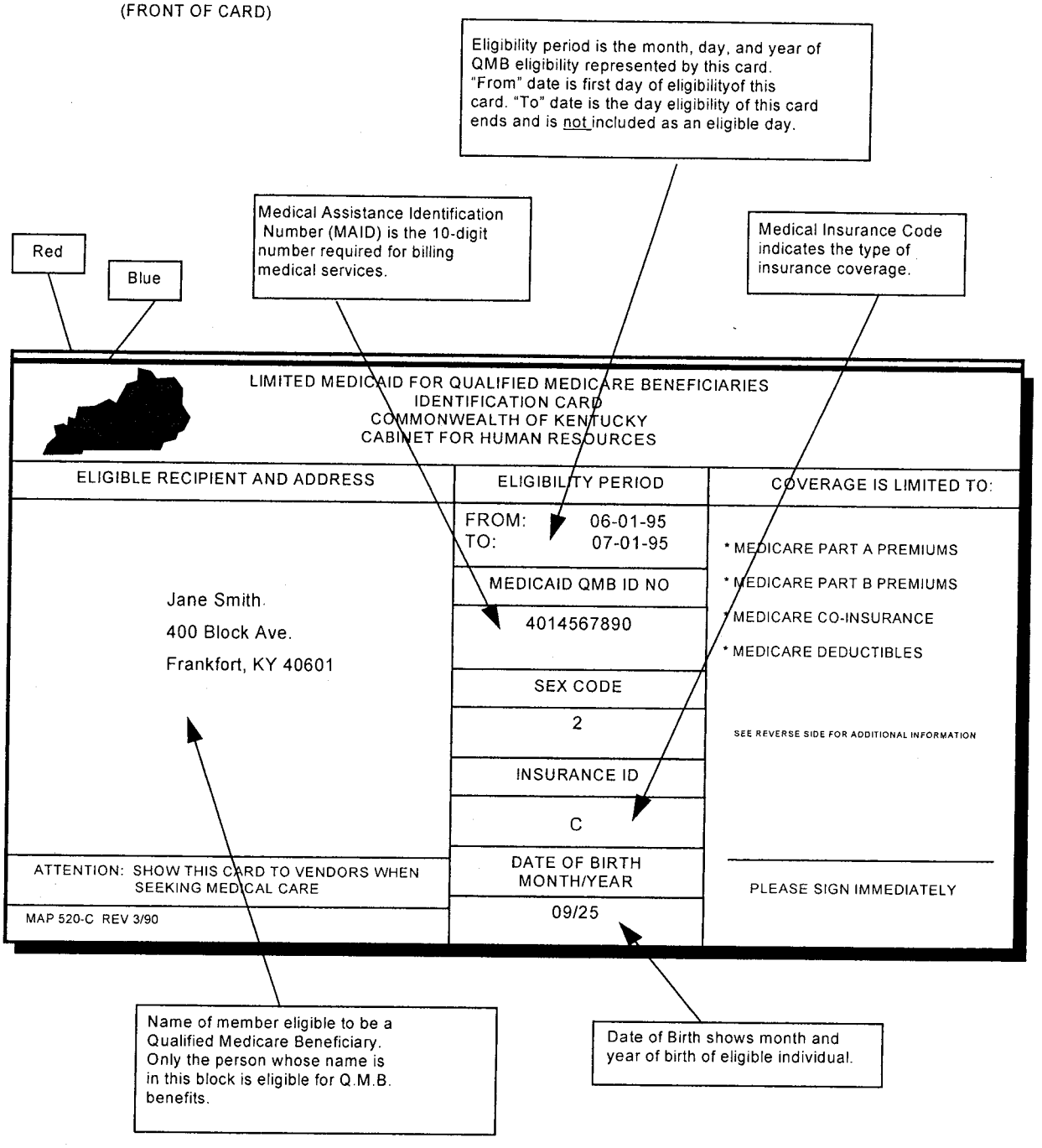


WHITE CARD (ALSO)

BACK OF QMB/MAID CARD

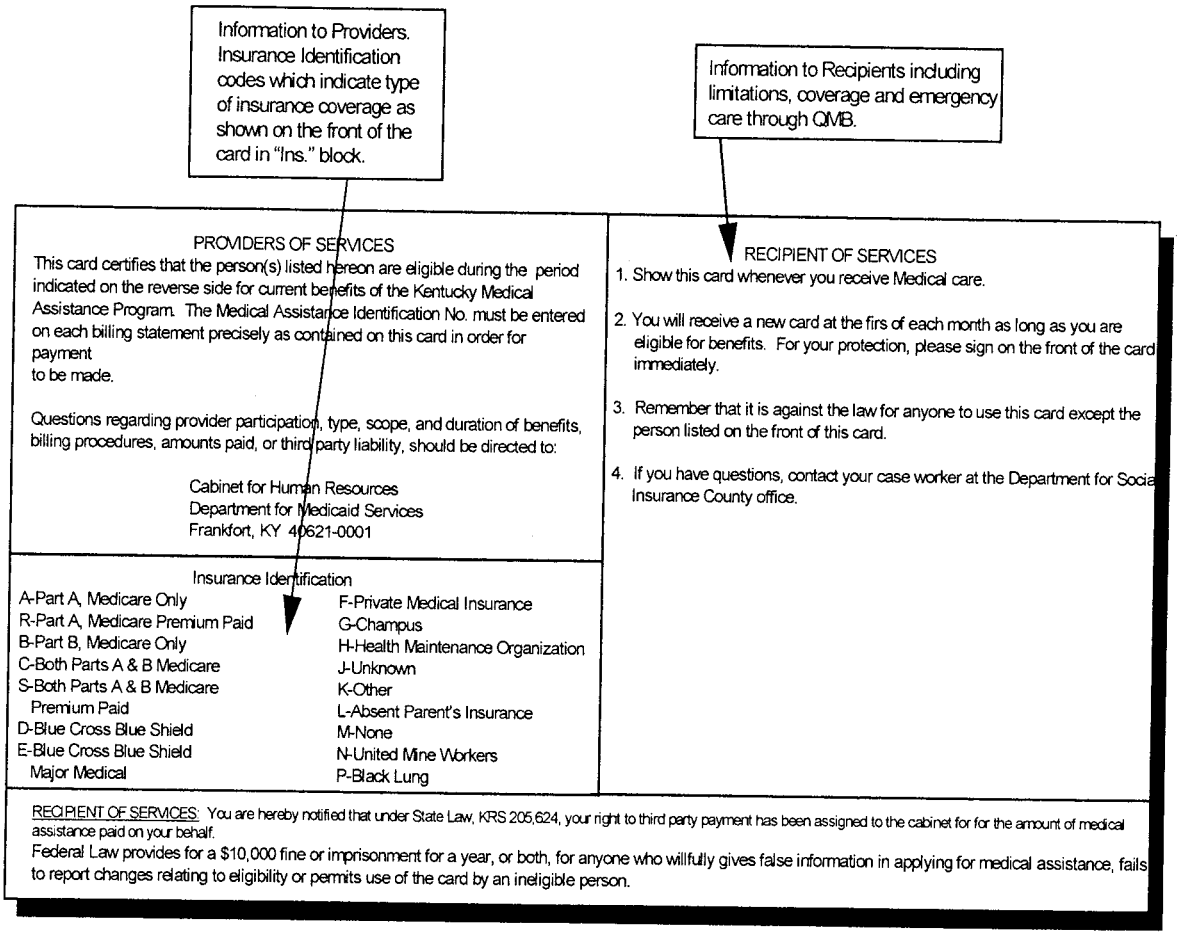


1.1.3. QMB IDENTIFICATION CARD



RED, WHITE, AND BLUE CARD

BACK OF QMB IDENTIFICATION CARD



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APPENDIX II - FORMS

MAP-4105
1/23/04

Kentucky Department for Medicaid Services

APPLICATION FOR TRANSFER TRAUMA EXEMPTION

Printed Name of Attending Physician: _____

PROVIDER INFORMATION

Name of Provider: _____ Provider # _____

Provider's Address: _____

_____

_____

RECIPIENT INFORMATION

Name of Recipient: _____ MAID # (or SS#)_____

Birth Date: _____ Age: _____ Sex: _____

Date of Admission: _____ Number of Consecutive Months at Facility: _____

JUSTIFICATION WHY THIS RECIPIENT WOULD BE HARMED UPON TRANSFERRING FROM THIS NURSING FACILITY:

_____

_____

_____

_____

_____

_____

_____

_____

_____

I attest that this is true and accurate information.

_____ _____

Attending Physician's Signature Date

CONTACT REGIONS FOR PASRR REFERRALS

REGION 1
Western KY MH/MR Board
P.O. Box 7287
Paducah, KY 42002
Tel: 502/442-7121

REGION 2
Pennyroyal MH/MR Board
735 North Drive
Hopkinsville, KY 42240
Tel: 502/886-5163

REGION 3
River Valley Behavioral
P.O. Box 1637
Owensboro, KY 42302
Tel: 502/684-0696

REGION 4
LifeSkills, Inc.
523 E. 12th Street
Bowing Green, KY 42101
Tel: 502/842-4887

REGION 5
Communicare, Inc.
1311 N.Dixie Avenue
Elizabethtown, kY 42701
Tel: 502/769-5301

REGION 6
Seven Counties Services,
Inc. 929 S. Third Street
Louisville, KY 40203
Tel: 502/585-2008

REGION 7
Northern Kentucky MH/MR
1201 S. Ft. Thomas Avenue
Fort Thomas, KY 41075
Tel: 606/781-5586

REGION 8
Comprehend, Inc.
611 Forest Avenue
Maysville, KY 41056
Tel: 606/564-4016

REGION 9
Pathways, Inc.
P.O. Box 790
Ashland, KY 41105-0790
Tel: 606/324-1141

REGION 10
Mountain MH/MR Board
150 S. Front Street
Prestonburg, KY 41653
Tel: 606/886-8572

REGION 11
KY. River Community Care
P.O. Box 587
Hyden, KY 41749
Tel: 606/678-4215

REGION 12
Area A
Cumberland River MH/MR
P.O. Box 568
Corbin, KY 40701
Tel: 606/528-7010

Area B
Cumberland River MH/MR
Mounted Route
Harlan, KY 40831
Tel: 606/337-6137

REGION 13
ADANTA
103 Reed Street
Colimbia, KY 42748
Tel: 502/384-5351

REGION 14
Bluegrass MH/MR Board
191 Doctors Drive
Frankfort, KY 40601
Tel: 502/223-1606

MAP-811
Provider Application Instructions

Enrollment Block:

- If applying for a Kentucky Medicaid number for the first time, check first block.
- If re-enrolling as a Kentucky Medicaid number, check second block and enter your eight(8) digit provider number in number 1.
- If a change in Federal Tax Identification number (FEIN) has occurred, check third block.
- If applicant has been excluded from Medicare/Medicaid by Federal, State, or court sanction please declare "I am enrolling as a reinstatement", check fourth block.

Section A: Administrative Information

Field #	Description
1	If a Medicaid provider number has already been assigned to this entity, please enter. Otherwise leave blank.
2	Enter License/Certificate number for the applicant.
3	Enter type of provider. EXAMPLE: physician; hospital; pharmacy; etc. Mark appropriate block for profit or non-profit.
4	Name of individual provider, practice or facility enrolling- mark the appropriate block.
5	Enter the name the provider will be doing business as, if different than field 4, otherwise you may enter N/A. If you are applying for an individual provider number, do not enter your employers name in this field.
6	Enter the type of service that will be provided. EXAMPLE: Acute care; diabetic supplies; etc...
7	Enter the date of your license or the date you wish your enrollment with Medicaid to be effective.
8	Only ICF/MR providers will enter the beginning and ending dates of their provider certification period; all other providers will enter N/A.
9	Name of person with signature authority.
10	Title of person with signature authority.
11	State individual Social Security number and date of birth.
12	State corporate Federal Tax Identification Number.
NOTE:	If you are an individual who has incorporated please enter both Federal Tax Identification Number and Social Security Number.
13	Enter the name of the person to sign for a summons in case of a lawsuit (N/A is not acceptable).
14	Telephone number of person named in number 13.
15	If you have held any Medicaid numbers in the past three years, list them here. If not mark N/A.
16	Physical address of applicant.
17	Physical county of applicant.
18	Physical city of applicant.
19	Physical state of applicant.
20	Physical zip code of applicant.
21	Physical telephone number of applicant.
22	Contact name and number.
23	Physical fax number of applicant.
24	Billing location telephone number.
25	Mailing address (where provider receives correspondence such as letters, newsletters, etc) if different from physical address.
26	Mailing city (follow instructions from number 25).
27	Mailing state (follow instructions from number 25).

28 Mailing zip code (follow instructions from number 25).
29 Enter E-mail address of applicant. (optional)
30 Pay-to-address (where providers will receive payment from Medicaid) if different from physical address.
31 Pay-to-address city (follow instructions from number 30).
32 Pay-to-address state (follow instructions from number 30).
33 Pay-to-address zip code (follow instructions from number 30).
34 If applicable, enter your National Provider Identification Number (NPI#), otherwise enter N/A.
35 If you are an individual, please list individual Medicare number; if you are an entity list entity Medicare numbers. If your Medicare number is pending, you must notify Unisys at the address below in writing when you receive your Medicare number.

Unisys Corporation
PO Box 2110
Frankfort, KY 40602-2110

NOTE: You must notify Provider Enrollment, in writing, what your Medicare number is and that you want it cross-referenced to your Medicaid provider number. Failure to do so will result in your claims not crossing over to Unisys for processing.

36 Enter your Unique Provider ID Number, otherwise enter N/A.
37 Enter the Drug Enforcement Agency number (DEA #).
38 Enter effective date of the DEA #.
39 Check block if Clinical Laboratory Improvement Agreement (CLIA) is attached.
40 Check this block if copy of any and all specialty licenses are attached.
41 If applying as a physician assistant please enter the supervising physician's name and Medicaid provider number.
42 Enter name of the software vendor (if doing own billing) or name of billing agency if someone else is submitting the claims electronically. Enter magnetic tape; 3.5-inch diskette; 5.25-inch diskette; Asynchronous PC Modem; Synchronous 3780 mainframe or Point of service.
43 If individual skip to Section B. If Hospital/Nursing Facility or ICF/MR must complete bed breakdown of facility.

NOTE: Chemical Dependency beds are not covered under the hospital provider type.

44 If facility has had a change in beds within the last 2 years, indicate the current bed count and the previous bed count plus the date the change occurred.
45 Enter the facility administrator's name with telephone and fax number.
46 Enter Assistant Administrator's name and telephone number.
47 Enter Controller with telephone number.
48 Enter Accountant with telephone number.
49 Enter Fiscal Year End (FYE).
50 This item is voluntary and used for statistics only.

Section B: Disclosure of Ownership and Control Interest

Field # Description

1 List current Medicaid provider numbers.
2 List current Medicare provider numbers.
3 If there has been a change of Federal Tax Identification number, please list previous Medicaid provider numbers and effective dates for each.
4 Describe relationship or similarities between the provider disclosing information on this form and items "A" through "C".

5 Do you plan to have a change in ownership, management company or control within the next year? If so, when?

6 Do you anticipate filing bankruptcy? If so, when?

7 State Federal Tax Identification Number if there is an affiliation with a chain along with name, address, city, state and zip code.

8 List name, address, SSN/FEIN of each person or organization having direct or indirect ownership or control interest in the disclosing entity. If owner by a corporation attach sheet with officers and board members names and social security numbers. (N/A is not acceptable).

NOTE: Do not send the list of board directors unless they own 5% or more.

Indirect Ownership Interest-means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Ownership interest- means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest- means a person or corporation that:

- Has an ownership interest totaling 5% or more in a disclosing entity
- Has an indirect ownership interest equal to 5% or more in a disclosing entity
- Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity.
- Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity
- Is an officer or director of a disclosing entity that is organized as a corporation or
- Is a partner in a disclosing entity that is organized as a partnership

9 List name, address and SSN/FEIN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.

Subcontractor- means an individual, agency, or organization to which a disclosing entity have contracted or delegate some of its management functions or responsibilities of providing medical care to its patients,
OR an individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment or services provided under the Medicaid agreement.

10 If applicant is related to persons listed in number 8 please list relationship.

11 List name of managing company, if not applicable enter N/A.

12 List names of the disclosing entities in which persons have ownership of other Medicare/Medicaid facilities.

Other Disclosing Entity- means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Act. This includes:

- Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII).
- Any Medicare intermediary of carrier.
- Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX or the Act.

13 If entity engages with subcontractors such as physical therapist, pharmacies, etc which exceeds the lesser of $25,000 or 5% of applicant's operating expense, please list subcontractors name and address.

Significant Business Transaction- means any business transaction or series of transactions that, during any on fiscal year, exceed the lesser of $25,000 or 5% of applicant's operating expense.

14 List name, Social Security Number, address of any provider who is authorized to prescribe drugs, medicine, devices, or equipment.

15 List anyone in number 7 whom has been convicted of a criminal offense related to the involvement of such persons or organizations in any problem established under Title 19 (Medicaid) or Title 20 (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state.

16 List any agent and/or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX or XX of the Social Security Act or any criminal offense in this state or any other state.

Agent- means any person who has been delegated the authority to obligate or act on behalf of a provider.

Managing Employee- means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

17 For any current or previous Medicaid provider, please list any changes in administrator; director of nursing; medical director.

18 Please indicate where you would like monies paid to you from Medicaid reported to for 1099 purposes. *Example: If you are an individual completing this question please input your Social Security Number unless you are a sole proprietor. A 64 provider can bill under his/her individual provider number even if they are working in a group setting.*

19 Please indicate the address you want your Medicaid 1099 mailed.

20 W-9 OR a copy of your Social Security Care OR a notarized statement thereof must be attached.

Section C: Tax Structure

Field # Description

1 Check block which pertains to applicants tax structure.

- If "B" is marked, please complete number 2 with name, address, city, state, zip code, and telephone number.
- If "C" is marked, please complete number 3 name, address, city, state, zip code and FEIN/SSN.
- If "E" is marked, please attach a list of Officer and Board Members.
- If "F" is marked, please attach list of Board Members.
- If "G" is marked, please attach list of Board Members.
- If "H" is marked, please attach list of Limited Liability members.

Page 10 (Signature Page)

Signature Block
Sign to ensure patient confidentially and privacy.

Provider Signature:

Name: enter original signature from the director, administrator, individual provider, owner, or authorized personnel.
Title: must be the tile of person signing. EXAMPLE: administrator; doctor; etc...
Date: enter the date the agreement was signed
Witnessed By: name of witness

Health Care Partnership Signature:
To be completed by Managed Care representative only

Regional Transportation Broker Signature:
This field to be completed by the transportation broker. All taxi, Ambulatory and non-ambulatory specialty carriers and bus-co-op must have this field completed. If field is incomplete the application will b e rejected for participation with the Kentucky Medicaid program.

Department for Medicaid Services Signature:
To be completed by Department for Medicaid Service representative only

MAP 811 Revised 04/04 *Fill out all Applicable Sections. Write Not Applicable (N/A) where appropriate. Please print or type.*

I am Enrolling as a:
- ☐ New Provider
- ☐ Re-applicant
- ☐ Change of Ownership/FEIN
- ☐ Re-Instatement

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
And/Or
KENTUCKY HEALTH CARE PARTNERSHIP

PROVIDER APPLICATION

SECTION A: ADMINISTRATIVE INFORMATION

1. _____
Current Medicaid Provider Number
(DMS will assign one if you are not a current provider.)

2. **License/Certification #** _____

3. **Type of Provider** _____ ☐ **For Profit** ☐ **NonProfit**

4. _____
Provider Name -OR- Entity Name Enrolling
☐ **Applying as Individual** ☐ **Applying as Entity/Group**

5. _____
Doing Business As (DBA) *(Other names also known as)*

6. _____
Type of Service

7. _____
Date Provider Requests Effective Enrollment

8. **ICF/MR/DD Only:**

If the named Provider in this agreement is an ICF/MR/DD this agreement shall begin on _____, 20____, with conditional termination on _____, 20____, unless the facility is re-certified in accordance with applicable regulations and policies.

9. _____
Name of Individual with Signature Authority

10. _____
Title of Individual with Signature Authority

11. **SSN:** [_][_][_][_][_][_][_][_][_] *and* **DOB:** [_][_] [_][_] [_][_][_][_]
Mo. Day Yr.

12. **FEIN (if applicable):** [_][_][_][_][_][_][_][_][_]

13. _____
Agent of Service in Case of Summons (N/A not acceptable.)

14. (_____)_____
Telephone # of Agent of Service **Ext. #**

15. **List any Medicaid *group* numbers you have held in the past three years.**

[_][_][_][_][_][_][_][_][_] [_][_][_][_][_][_][_][_][_] [_][_][_][_][_][_][_][_][_]

State primary physical business location in 16 through 20. If you have more than one physical location, attach a copy of items 16-26, listing additional locations.

16. _____
Address

17. _____
County

18. _____
City

19. [____][____] 20. _____-_____
State (2-digit) **Zip**

21. (_____)_____
Telephone # **Ext.**

22. _____
Contact Name

23. (_____)_____
Fax #

24. (_____)_____
Billing Location Telephone # **Ext.**

MAP 811 Revised 04/04 *Fill out all Applicable Sections. Write Not Applicable (N/A) where appropriate. Please print or type.*

State MAILING Address(*if different from physical address)* in items 25 - 28.

25. _____ **Address**

26. _____ **City**

27. [___][___] **State**

28. _____-_____ **Zip**

29. **Email Address (optional)**_____ **Note:** Your email address will not be given to any outside party for any reason. DMS may use provider email addresses to send provider letters/notices.

State PAY-TO Address (*if different from physical address)* for items 30 – 33.

30. _____ **Address**

31. _____ **City**

32. [___][___] **State**

33. _____-_____ **Zip**

34. _____ **NPI (National Provider Identifier)**

35. **Please list all Medi*care* Provider Numbers. (Attach extra sheet if necessary.)**

(a) _____ (b) _____ (c) _____

36. _____ **UPIN #**

37. _____ **DEA #**

38. _____ **DEA # Effective Date**

39. **Attach a copy of CLIA**
☐ *I have attached a copy.*

40. **Attach a copy of specialty certification.**
☐ *I have attached a copy.*

41. **If you are applying as a Physician Assistant please indicate supervising Physician name & provider number.**

Name_____ **Provider Number**_____

42. **If you wish to BILL ELECTRONICALLY:**

_____ **Software Vendor and/or Billing Agency**

_____ **Media**

Facilities only complete 43 through 49.

43. Bed Breakdown

[__][__][__] Acute [__][__][__] ICU [__][__][__] Surgical ICU [__][__][__] Burn ICU
[__][__][__] TCU [__][__][__] Nursery [__][__][__] Neonatal ICU [__][__][__] CCU
[__][__][__] Hosp. Swing [__][__][__] Rehab. Hosp. [__][__][__] Psych. Hosp. [__][__][__] PRTF

[__][__][__] ICF/MR/DD [__][__][__] Ventilator Unit [__][__][__] Brain Injury Unit

[__][__][__] NF/Medicaid [__][__][__] NF (Medicare/Medicaid)

[__][__][__] Other /specify:_____

44. If your bed capacity has increased by 10% OR by 10 beds, whichever is greater, within the last two (2) years, , give current bed and prior bed counts and the date change occurred:

[__][__][__][__] Current Bed Count

[__][__][__][__] Prior Bed Count

_____ Date of Change

45. _____ (_____)_____
Administrator Phone Number Ext.
(_____)_____
Fax #

46. _____ (_____)_____
Assistant Administrator Phone Number Ext.

47. _____ (_____)_____
Controller Phone Number Ext.

48. _____ (_____)_____
Accountant or **CPA** Phone Number Ext.

49. **Fiscal Year Ends Date (FYE)** _____.

50. **For statistical purposes only. Not required.**

Race:_____ **Sex (circle one):** **M** **F**

The Program Integrity Division in the Department for Medicaid Services, oversee the Lock-In Program. Lock-In "locks" a recipient to one provider and one pharmacy for one year at a time, if there is reason to believe that a recipient is over-utilizing services. If you would like additional information, please call (502) 564-1012.

SECTION B: DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST

ITEMS 1-9 BELOW ARE REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR 455.104 AND KRS CHAPTER 205, AS AMENDED). YOU WILL RECEIVE THIS SECTION ANNUALLY TO UPDATE AND RETURN TO DMS.

Note: See page 8 for definitions according to 42 CFR 455.101 and 455.104 and KRS Chapter 205, as amended, of underlined terms in Section B.

1. List all current Medicaid provider numbers: [_][_][_][_][_][_][_][_][_] [_][_][_][_][_][_][_][_][_]

2. List all current Medicare provider numbers: [_][_][_][_][_][_][_][_][_][_][_][_]

3. If there has been a change in ownership, change of tax ID number (FEIN), or change in Kentucky Provider Number for a previously enrolled Kentucky Medicaid provider, please state previous provider number(s) and their effective date(s):

Previous Medicaid Prov. #	Mo.	Day	Yr.	*to*	Mo.	Day	Yr.
[_][_][_][_][_][_][_][_][_]	[_][_]	[_][_]	[_][_]		[_][_]	[_][_]	[_][_]
[_][_][_][_][_][_][_][_][_]	[_][_]	[_][_]	[_][_]		[_][_]	[_][_]	[_][_]

4. If you completed #3, describe the relationship between the provider disclosing information on this form, and the following: (a) previous Medicaid owner (b) corporate boards of disclosing provider and previous Medicaid owner; i.e. board members and ownership or control interest (c) disenrollment circumstances. Attach extra page if necessary.

_____

_____

5. If you anticipate any change of ownership, management company or control within the year, state anticipated date of change and nature of the change. Date: _____ Change: _____

6. If you anticipate filing for bankruptcy within the year, state anticipated date of filing. _____

7. If this facility is a subsidiary of a parent corporation, state corporate FEIN #: _____

   Name: _____

   Box or Address: _____

   City: _____

   State:[____][____] Zip: _____-_____

8. List name, date of birth, SSN#/FEIN#, and address of each person or organization that owns 5% or more direct or indirect ownership or controlling interest in the applicant provider. If owned by a corporation, please list names and social security numbers of Officers and Board Members of that corporation. (Attach extra page if necessary.) (N/A not acceptable.)

   [_] **Check here if no one has 5% or more direct or indirect ownership, and skip to item #9.**

   NAME (a): _____ DOB: _____

   Box or Address: _____ SSN: _____

   -and/or-

   City: _____ FEIN: _____

   State:[____][____] Zip: _____-_____

NAME (b): _____ DOB: _____

Box or Address: _____ SSN: _____
-and/or-
City: _____ FEIN: _____

State:[____][____] Zip: _____-_____

9. List name, address, SSN#, FEIN# of each person with an ownership or control interest in any subcontractor in which the provider applicant has direct or indirect ownership of 5% or more. Attach extra page if necessary.

NAME (a): _____ SSN: _____
-and/or-
Box or Address: _____ FEIN: _____

City: _____

State:[____][____] Zip: _____-_____

NAME (b): _____ SSN: _____
-and/or-
Box or Address: _____ FEIN: _____

City: _____

State:[____][____] Zip: _____-_____

10. If any individuals listed in item #8 (above) are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.)

Name: _____ Name: _____

Relationship: _____ Relationship: _____

SSN: _____ SSN: _____
-and/or- -and/or-
FEIN: _____ FEIN: _____

11. If this facility employs a management company, please provide following information:

Name: _____

Box or Address: _____

City: _____

State:[____][____] Zip: _____-_____

12. List the names of any other disclosing entity in which person(s) listed on this update ownership of other Medicare/Medicaid facilities.

NAME (a): _____ Provider #: _____

Box or Address: _____

City: _____

State:[____][____] Zip: _____-_____

NAME (b): _____ Provider #: _____

Box or Address: _____

City: _____

State:[____][____] Zip: _____-_____

13. List the names and addresses of all other Kentucky Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of $25,000 or 5% of your total operating expense. (Attach extra page if necessary.)

NAME (a): _____

Box or Address: _____

City: _____

State:[____][____] Zip: _____-_____

NAME (b): _____

Box or Address: _____

City: _____

State:[____][____] Zip: _____-_____

14. List the name, SSN, and address of any immediate family member who is authorized under Kentucky Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment in accordance with KRS 205.8477.

NAME(a): _____ Credential (M.D., etc.): _____

Box or Address: _____ DOB: _____

City: _____ SSN: _____

State: [____][____] Zip: _____-_____

NAME(b): _____ Credential (M.D., etc.): _____

Box or Address: _____ DOB: _____

City: _____ SSN: _____

State:[____][____] Zip: _____-_____

15. List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state, since the inception of those programs. (Attach extra page if necessary.)

NAME (a) _____ NAME (b) _____

16. List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state. (Attach extra page if necessary.)

NAME (a) _____ NAME (b) _____

17. For any previously enrolled Medicaid provider, please list any change in:

Administrator: _____ Director of Nursing (DON): _____

Medical Director: _____

18. DMS will report all monies paid to you to the IRS. Please indicate which number you use for tax reporting:

Report DMS payments to my FEIN: [__][__][__][__][__][__][__][__][__]

Report DMS payments to my SSN: [__][__][__][__][__][__][__][__][__]

19. Where do you want your Medicaid 1099 (annual earnings form) mailed?

Name: _____

Box or Address: _____

City: _____

State:[____][____] Zip: _____-_____

20. (_____)_____ **21.** Contact Person _____
Telephone # **Ext.**

22. If you are a Kentucky Medicaid Group (more than one professional of the same provider type) please attach a listing of all professionals currently employed in your group. Include the provider name, begin date with the group and the individuals Kentucky Medicaid provider number.

23. Please attach a copy of your **W-9** form, "Request for Taxpayer Identification Number and Certification" **OR** a copy of your Social Security Card **OR** a notarized statement thereof.

455.104 Definitions:

1. Indirect Ownership Interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
2. Other Disclosing Entity Means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:
   (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII):
   (b) Any Medicare intermediary or carrier; and
   (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishings of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.
3. Person with an Ownership or Control Interest means a person or corporation that:
   (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
   (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
   (c) Has a combination of direct or indirect ownership interests equal to 5 percent or more in a disclosing entity;
   (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
   (e) Is an officer or director of a disclosing entity that is organized as a corporation; or
   (f) Is a partner in a disclosing entity that is organized as a partnership
4. Subcontractor means:
   (a) An individual, agency, organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
   (b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

SECTION C: TAX STRUCTURE

1. Provider Tax Structure of Applicant: Please check only one (1).

   - ☐ (A) Individual (applying for an individual number)
   - ☐ (B) Sole Proprietor (applying for an individual number)
   - ☐ (C) Partnership (whether applying for an individual or group number)
   - ☐ (D) Estate/Trust
   - ☐ (E) Corporation
   - ☐ (F) Public Service Corporation
   - ☐ (G) Government/Non-Profit
   - ☐ (H) Limited Liability Company

2. If tax structure is (B) Sole Proprietor, give name, d.b.a. (if applicable), address, and telephone number of owner:

   _____
   Name (and d.b.a. if applicable)

   _____ _____
   Address City

   [___][___] _____-_____ (_____)_____
   State (2-digit) Zip Telephone # Ext.

3. If tax structure is "C" Partnership, list name, address, and the social security numbers of partners:

Name	Address	SSN

4. If tax structure is (E) Corporation, please attach a list of Officers and Board Members' names or list below.
   ☐ *I have attached a list*

5. If tax structure is (F) Public Service Corporation, please attach a list of Board Members' names or list below.
   ☐ *I have attached a list.*

6. If tax structure is (G) Government/Non-Profit, please attach a list of Board Members' names or list below.
   ☐ *I have attached a list.*

7. If tax structure is (H) Limited Liability, please attach a list of the members.
   ☐ *I have attached a list.*

MAP 811 Revised 04/04 *Fill out all Applicable Sections. Write Not Applicable (N/A) where appropriate. Please print or type.*
WHOEVER KNOWINGLY OR WILLFULLY MAKES, OR CAUSES TO BE MADE, A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT SHALL BE SUBJECT TO PROSECUTION UNDER APPLICABLE FEDERAL OR STATE LAWS. (42USC 1320A-7B, CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS IS PRINTED ON PAGE 13) FAILURE TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED SHALL RESULT IN A DENIAL OF A REQUEST TO PARTICIAPTE IN OR TERMINATION OF THE CURRENT AGREEMENT WITH THE STATE AGENCY, AS REQUIRED BY 42 CFR 455.104 AND KRS CHAPTER 205 AS AMENDED.

Provider Authorized Signature: I certify, under penalty of law, that the information given in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or for prosecution for Medicaid fraud. I certify that I have read and understand the "Medicaid Rules, Regulation, Policy and 42USC 1320a-7b" (pp. 11-13) to the best of my ability. I agree to abide by the Medicaid Program terms and conditions listed in this document, and I hold a license/certification to provide service corresponding to the information above and for which this agreement applies. I hereby authorize the Cabinet for Health Services, the Kentucky Health Care Partnership to make all necessary verification concerning me and/or my medical practice/facility, and further authorize each educational institute, medical/license board or organization to provide all information that may be needed in connection with my application for participation in the Kentucky Medicaid Program.

If you keep medical records on an electronic database, you must certify by signature that electronic records are confidential and patient privacy is protected (KRS 205.510).

Provider Signature: _____ **Date:** _____

Provider Signature:

Name: _____

Title: _____

Date: _____

Witnessed By: _____

Health Care Partnership Signature:

Name: _____

Title: _____

Date: _____

Regional Transportation Broker Signature:

Broker Name: _____

Broker Signature: _____

Approval Date: _____

Department for Medicaid Services Signature:

Name: _____

Title: _____

Date: _____

PLEASE MAKE A COPY OF COMPLETED PAGES FOR YOUR RECORDS. YOU WILL RECEIVE A DMS-SIGNED COPY OF THIS PAGE ALONG WITH NOTIFICATION OF YOUR KENTUCKY MEDICAID PROVIDER NUMBER.

MEDICAID RULES, REGULATION, POLICY AND 42USC 1320a-7b

1. **Scope of Agreement:**

This provider agreement sets forth the rights, responsibilities, terms and conditions governing the provider's participation in the Kentucky Medicaid Program, KenPAC, KCHIP and/or Kentucky Health Care Partnership and supplements those terms and conditions imposed by these four (4) programs.

2. **Medical Services to be Provided:**

The provider agrees to provide covered services to Medicaid, KenPAC and KCHIP recipients in accordance with all applicable federal and state laws, regulations, policies and procedures relating to the provision of medical services according to Title XIX, Title VI, the approved Waivers for Kentucky and, for those providers participating in the Partnership, all applicable provisions of the pertinent contract for managed care and policies and procedures duly adopted by the governing board of the Partnership applicable to provider and recipients of Title XIX services.

3. **Assurances:**

The Provider:

(1) Agrees to maintain such records, including electronic storage media, as are necessary to document the extent of services furnished to KCHIP and Title XIX recipients for a minimum of five (5) years or as required by state and federal laws, and for such additional time as may be necessary in the event of an audit exception, quality of care issue, or other dispute and to furnish the state or federal agencies with any information requested regarding payments claimed for furnishing services.

(2) Agrees to permit representatives of the state and federal government, and, for those providers participating in the Partnership, staff of the Kentucky Health Care Partnership to have the unrestricted right to examine, inspect, copy and audit all records pertaining to the provision of services furnished to KCHIP and Title XIX recipients. Such examinations, inspections, copying and audits may be made without prior notice to the Provider. This right shall include the ability to interview facility staff during the course of any inspection, review, investigation or audit.

(3) Agrees to comply with the Civil Rights requirements set forth in 45 CFR Parts 80, 84, and 90 and the Americans with Disabilities Act (ADA), 42 USC 12101. Payments shall not be made to providers who discriminate on the basis of race, color, national origin, sex, disability, religion, age or marital status in the provision of services.

(4) Agrees to cooperate with applicable public health agencies to coordinate appropriate medical care for KCHIP and Title XIX recipients in order to ensure quality of care and avoid the provision of duplicate or unnecessary medical services.

(5) Assures awareness of the provisions of 42 USC 1320a-7b reproduced on page 12 of this agreement and of the provisions of KRS 205.8451 to KRS 205.8483 relating to Medicaid Program Fraud and Abuse, and applicable Kentucky Administrative Regulations as specified in Title 907 relating to the Kentucky Health Care Partnerships and Provider Agreements.

(6) Agrees to inform the Cabinet for Health Services, Department for Medicaid Services or the appropriate Partnership.

A. within thirty (30) days of any change in the following:
   1. name;
   2. ownership.
   3. address; and

B. within five (5) days of information concerning the following:
   1. change in licensure/certification;
   2. regulation status;
   3. disciplinary action by the appropriate professional association; and
   4. criminal charges

(7) Agrees to the following:
   A. To assume responsibility for appropriate, accurate, and timely submission of claims and encounter data whether submitted directly by the provider or by an agent;
   B. To use EMC submittal procedures and record layouts as defined by the Cabinet if submitting electronic claims.
   C. That the provider's signature on this agreement constitutes compliance with the following: the transmitted information is true, accurate and complete and any subsequent correction which alter the information contained therein will be transmitted promptly;
   D. Payment and satisfaction of claims will be from federal and state funds and that any false claims, statements, or documents or concealment of falsification of a material fact, may be prosecuted under applicable federal and state law.

(8) Agrees to participate in the quality assurance programs of the partnership and the Department for Medicaid Services and understands that the data will be used for analysis of medical services provided to assure quality of care according to professional standards.

(9) A contract for the sale or change of ownership participating in the Medicaid Program shall specify whether the buyer or seller is responsible for the amounts owed to the department by the provider, regardless of whether the amounts have been identified at the time of sale. In the absence of such specification in the contract for the sale or change of ownership, the owners or the partners at the time the department paid the erroneous payments have the responsibility for liabilities arising from those payments, regardless of when identified.

(10) Agrees to notify the Department for Medicaid Services and/or the Partnership in writing of having filed for protection from creditors under the Bankruptcy code within five (5) days of having filed a petition with the court. Notification shall include the number assigned the case by the court, and the identity of the court in which the petition was filed.

(11) Agrees to return any overpayment made by the Department for Medicaid Services and/or Partnership resulting from agency error in calculation of amount or review of submitted claims.

(12) Agrees to refund the Kentucky State Treasurer, the processing fee incurred by the fiscal agent for the Department for Medicaid Services in the event claim submission has an error rate of 25% or greater.

4. ITEM # 4 APPLIES ONLY TO LONG TERM CARE FACILITES (NF, ICF/MR or Mental Hospital), AND HOME COMMUNITY BASED Waiver SERVICES (HCB, SCL, Model Waiver II, Acquired Brain Injury, etc.)

As a result of the Medicare Catastrophic Coverage Act of 1988, each facility providing long term care services agrees to advise all new admissions of resource assessments to assist with financial planning performed by the Department for Community Based Services through a contractual arrangement with the Department for Medicaid Services. This requirement is a Condition of Participation in the Kentucky Medicaid Program, in accordance with 907 KAR 1:672 and is effective with new admissions on and after September 30, 1989.

Each nursing facility agrees to comply with the preadmission screening and resident review requirement specified in Section 1919 of the Social Security Act, effective with regard to admissions and resident stays occurring on or after January 1, 1989.

5. Payment:

In consideration for the provision of approved Title XIX services rendered to Medicaid recipients and Title XXI services rendered to KCHIP recipients and subject to the availability of federal and state funds;

(1) The Cabinet for Health Services, Department for Medicaid Services agrees to reimburse the provider according to current applicable federal and state laws, rules and regulations and policies of the Cabinet for Health Services for providers participating as direct Medicaid payment providers. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Health Services, Department for Medicaid Services.

(2) The Partnership agrees to reimburse the provider according to the provisions of the Partnership agreement with the provider. Payments shall be made only upon receipt of appropriate encounter data, claims and reports as prescribed by the Partnership governing board.

(3) In accordance with 42 CRF 447.15, if the department makes payment for a covered service and the provider accepts this payment in accordance with the department's fee structure, the amounts paid shall be considered payment in full; a bill for the same service shall not be tendered to the recipient, and a payment for the same service shall not be tendered to the recipient, and a payment for the same service shall not be accepted from the recipient. A provider may not bill a Medicaid recipient for a bill that was denied due to incorrect billing. A provider may bill a Medicaid recipient under the following conditions:

a. Service not covered by Kentucky Medicaid, and member was previously informed of the non-covered service.
b. Provider is not enrolled in Kentucky Medicaid.

6. Provider Certification:

(1) If the provider is required to participate or hold certification under Title XVIII of the Social Security Act to provide Title XIX services, the provider assures such participation or certification is current and active.

(2) If the Provider is a specialty hospital providing psychiatric services to persons age twenty-one (21) and under, the Provider shall be approved by the Joint Commission on Hospitals or the Council on Accreditation of Services for Families and Children or any other accrediting body with comparable standards that are recognized by the state. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on the Accreditation of Health Care Organizations.

(3) Home Care Waiver Services agrees to comply with the conditions for participation established in 907 KAR 1:070. All staff shall meet all training requirements prior to providing services.

(4) Personal Care Assistance Programs agree to comply with the conditions for participation established in 907 KAR 1:090. All staff shall meet all training requirements prior to providing services.

7. Lobbying Certification:

The provider certifies that to the best of one's knowledge and belief, that during the preceding contract period, if any, and during the term of this agreement:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influence or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee or Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL 'Disclosure Form to Report Lobbying' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

(4) This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into, submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352 Title 31. US code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

8. Termination

(1) The Department for Medicaid Services and/or partnership or provider shall have the right to terminate this agreement for any reason up thirty (30) days written notice served upon the other party by registered mail with return receipt requested. The Partnership and/or Department for Medicaid Services may terminate this agreement immediately for cause, or in accordance with state or federal laws, upon written notice served upon the Provider by registered mail with return receipt requested.

(2) If Medicare or Medicaid terminates the provider, the Partnership shall also terminate the provider from participation.

(3) If there is a change of ownership of nursing facility, the Cabinet for Health Services agrees to automatically assign this agreement to the new owner according to 42 CFR 442.14.

(4) Failure of a provider to comply with the terms of this agreement may result in the initiation of the following sanctions:

- Freezing member enrollment with the provider.
- Withholding all or part of the provider's monthly management fee.
- Making a referral to the Department's Division of Program Integrity for investigation of potential fraud or quality of care issues.
- Terminating the provider from the KenPAC program.

The Department will allow the provider two weeks to cure any violation that could result in the sanctioning of the provider. If the provider does not or refuses to cure the violation, the Department will proceed with action to impose sanctions on the provider. If sanctions are applied against the provider, the action will be reported to the appropriate professional boards and/or agencies. One or more of the above sanctions may be initiated simultaneously at the discretion of the Department based on the severity of the contraction violation. The Commissioner makes the determination to initiate sanctions against a provider. The provider will be notified of the initiation of a sanction by certified mail.

42USC Section 1320a-7b. Criminal Penalties for Acts Involving Federal Health Care Programs

(a) Making or causing to be made false statements or representations
Whoever-
(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program (as defined in subsection (f) of this section),
(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized.
(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,
(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a Federal health care program and knows that the individual who furnished the service was not a licensed physician, or
(6) knowingly and willfully disposed of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under subchapter XIX of this chapter, if disposing of the assets in the imposition of a period of ineligibility for such assistance under section 1396p© of this title, shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which the payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement , representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such periods (not exceeding one year) as it deems appropriate, but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between the individual and such other person.

(b) Illegal remunerations
(1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind
(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.
(2) whoever knowingly and willfully offers or pays any remuneration (including kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person-
(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.
(3) Paragraphs (1) and (2) shall not apply to-
(A) a discount or other reduction in price obtained by a provider of services or other entity under a Federal health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a Federal health care program;
(B) any amount paid by an employer (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services;
(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under a Federal health care program if-
(i) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and
(ii) in the case of an entity that is a provider of services (as defined in section 1395x(u) of this title), the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;
(D) a waiver of any coinsurance under part B of subchapter XVIII of this chapter by a Federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act {42 U.S.C.A. section 201 et seq.};
(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid patient and Program Protection Act of 1987; and
(F) any remuneration between an organization and an entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1395mm of this title or if the written agreement, through a risk-sharing arrangement, places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide.

(c) False statements or representations with respect to condition or operation of institutions
Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution, facility, or entity in order that such institution, facility, or entity may qualify (either upon initial certification or upon rectification) as a hospital, rural primary care hospital, skilled nursing facility, intermediate care facility for the mentally retarded, home health agency, or other entity (including n eligible organization under section 1395mm(b) of this title) for which certification is required under subchapter XVIII of this chapter of a State health care program (as defined in section 1320a-7(h) of this title), or with respect to information required to be provided under section 1320-a-3a of this title, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Illegal patient admittance and retention practices
Whoever knowingly and willfully-
(1) charges, for any service provided to a patient under a State plan approved under subchapter XIX of this chapter, money or other consideration at a rate in excess of the rates established by the State, or
(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under subchapter XIX of this chapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)-
(A) as a precondition of admitting a patient to a hospital, nursing facility, or intermediate care facility for the mentally retarded, or
(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(e) Violation of assignment terms
Whoever accepts assignments described in section 1395u(b)(3)(B)(ii) of this title or agrees to be a participating physician or supplier under section 1395u9h)(1) of this title and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.

(f) "Federal health care program" defined
For purposes of this section, the term "Federal health care program" means-
(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the Unites States Government (other than the health insurance program under chapter 89 of Title 3), or
(2) any State health care program, as defined in section 1320a-7(h) of this title.

MAP-726A
Revised 9/2003

NURSING FACILITY LEVEL OF CARE
REQUEST FOR ADMISSION

Resident Name _____ Medicaid # _____-_____-_____

Room # _____ Room Certified for Medicaid ☐ Yes ☐ No

If Pending Medicaid, Social Security # _____-_____-_____

Medicare # _____ Date of Birth _____/_____/_____

Marital Status ☐ M ☐ W ☐ S ☐ D ☐ Male ☐ Female

Responsible Party _____

Responsible Party Address _____

Relationship _____

Diagnoses _____

_____

_____

Living Arrangements Prior To Admission _____

_____

CHECK ONE ONLY:

☐ New Admit Date _____/_____/_____

☐ Readmit Date _____/_____/_____

☐ Pay Source Change Date _____/_____/_____

(Last Admit Date _____/_____/_____)

Admission or Readmission From:	
Acute Care Hospital	
Free-Standing Psychiatric Hospital	
Home	
ICF/MR/DD	
Nursing Facility	
Personal Care Home	
Other:	

MAP-726A
Revised 9/2003

NURSING FACILITY LEVEL OF CARE
REQUEST FOR ADMISSION

***PASRR LEVEL I FORM (AND IF APPLICABLE, THE LEVEL II FORM) MUST BE COMPLETED AND A COPY FAXED WITH ALL NEW ADMISSIONS AND ALL PAY SOURCE CHANGES.**

Level I PASRR Date _____/_____/_____ Completed By _____

Level II PASRR Date _____/_____/_____ Appropriate for NF Placement? ☐ Yes ☐ No

Completed By _____

Verbal Determination Form
(Mental Illness Only) Date _____/_____/_____ Appropriate for NF Placement? ☐ Yes ☐ No

Completed By _____

Inappropriate Referral Date _____/_____/_____ Completed By _____

NF Name	Facility ID # Phone ( )
Physician Name Address	Physician Phone ( ) Fax # ( )
Physician License #	
MEDICATIONS	
Describe resident's medications: Number of Oral, Tube, Topical, Inhalers, Sprays, or Patches. List the name and frequency of any IV, SQ, or IM medications (include routine flushes), Routine Administration of Oxygen (i.e., new administration of oxygen or regulating oxygen, how often checking pulse oximetry, etc.) and Nebulizer Treatments.	

Is resident capable of self-administering medications? ☐ Yes ☐ No If no, why_____

_____

MAP-726A
Revised 9/2003

NURSING FACILITY LEVEL OF CARE
REQUEST FOR ADMISSION

NUTRITIONAL STATUS

Type of Diet	☐ Regular ☐ Low Sodium ☐ Healthy Heart ☐ Other
Height	Weight
Feeding	☐ Independent with Tray Set Up ☐ Receives Partial Hands on Assist to Eat ☐ Total Feed ☐ Continuous Verbal Cues
Tube Feeding Required	☐ Yes ☐ No If Yes, Explain Amount _____ Brand _____ Frequency _____ H20 Flushes & Frequency _____

SKIN CONDITIONS

Number of Decubitus Ulcers	Stage 1	Stage 2	Stage 3	Stage 4
Type of Ulcer	Pressure/Stasis	Pressure/Stasis	Pressure/Stasis	Pressure/Stasis
Treatment				
Other Skins Problems				
Treatment				

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Revised 9/2003

NURSING FACILITY LEVEL OF CARE
REQUEST FOR ADMISSION

THERAPIES

Physical Therapy	Y N	Days Per Week:	Comments:
Occupational Therapy	Y N	Days Per Week:	Comments:
Speech Therapy	Y N	Days Per Week:	Comments:
Respiratory Therapy	Y N	Days Per Week:	Comments:

NURSING REHABILITATION/RESTORATIVE CARE

a. Range of Motion (Passive)	Y N	Days Per Week:	Comments:
b. Range of Motion (Active)	Y N	Days Per Week:	Comments:
c. Splint or Brace Assistance	Y N	Days Per Week:	Comments:
d. Bed Mobility	Y N	Days Per Week:	Comments:
e. Transfer	Y N	Days Per Week:	Comments:
f. Walking	Y N	Days Per Week:	Comments:
g. Dressing or Grooming	Y N	Days Per Week:	Comments:
h. Eating or Swallowing	Y N	Days Per Week:	Comments:
i. Amputation/Prosthesis Care	Y N	Days Per Week:	Comments:
j. Communication	Y N	Days Per Week:	Comments:
k. Toileting	Y N	Days Per Week:	Comments:

MAP-726A
Revised 9/2003

NURSING FACILITY LEVEL OF CARE
REQUEST FOR ADMISSION

Additional Safety/Health Information Pertinent to Admission (i.e., Wanderguard, bed/chair alarm, locked unit/building, full side rails, etc.)

PLEASE FAX **ALL PASRR** INFORMATION WITH **NEW ADMISSION** REQUESTS.

I certify that the MAP-726A information was reviewed by me. I attest that the foregoing information is true, accurate and complete.

_____ /____/_____
RN/LPN Signature Date

_____ / /
Person Faxing Request Date

( ) ( )
Telephone Number Fax Number

MAP-524
(R. 1/1/03)

COMMONWEALTH OF KENTUCKY
Cabinet for Health Services
Department for Medicaid Services

MEDICAID NURSING FACILITY SERVICES FACT SHEET

What are Medicaid Nursing Facility Services?

Nursing facility (NF) services include room, dietary services, social services, nursing services, the use of equipment and facilities, medical and surgical supplies, laundry services, drugs ordered by the physician and personal items routinely provided by the facility. Also included, if ordered by the physician, are x-rays, physical therapy, speech therapy, occupational therapy, laboratory services and oxygen, and related oxygen supplies.

Who is Eligible for Nursing Facility Services?

You may be eligible for NF services if:

- You reside in a facility that participates in the Kentucky Medicaid Program and are placed in a Medicaid certified bed;
- You require and meet the level of care for skilled nursing services, intermediate care services, intermediate care services for the mentally retarded and the developmentally disabled, or nursing facility services; and
- You are aged sixty-five (65) years or older, blind or disabled, or are currently Medicaid eligible.

What are Resources?

Resources are cash money and any other personal property or real property that you own, may convert to cash; and could use for support and maintenance. Resources include checking and savings accounts, stocks or bonds, certificates of deposit, automobiles, land, buildings, burial reserves and life insurance policies, and more.

We do not use some resources in determining Medicaid eligibility. These resources include the home, household goods and personal effects, the first $1,500 of a burial reserve or a life insurance policy, one automobile used for work, medical treatment, or by the community spouse, burial spaces and plots, life estate interests, and IRA, Keoghs, retirement funds and other tax deferred assets (until accessed).

Your resources must be within Medicaid resource guidelines. The resource limits vary if you are married and we count your spouse's resources.

Marital Status	Living Arrangement	Resource Limit
Single Person	NF Resident	$ 2,000
Married Couple	Both NF Residents	$ 4,000
Married Couple	NF resident with spouse who is still at home	$ 92,660

What is a Resource Assessment?

You, your spouse or someone representing you may ask the Department for Community Based Services (DCBS) to make an assessment of your combined countable resources. You do not have to apply for Medicaid to get a resource assessment. The resource assessment involves documenting and verifying all countable resources owned by you and your spouse at the time of the most recent NF admission. The assessment compares the combined countable resources to the current Medicaid limits to determine if you meet Medicaid resource guidelines.

Contact DCBS in the county where you live to request a resource assessment. DCBS will give you and your spouse copies of the completed assessment.

What are Transferred Resources?

If you or your spouse transfers resources, you may not be able to get Medicaid NF services. Transferred resources are cash, liquid assets, personal property, or real property, which are voluntarily transferred, sold, given away, or otherwise disposed of for less than fair market value. If you transfer resources in the 3 year period before the Medicaid application month (or 5 years for a trust) DCBS assumes that the transfer was made to qualify for Medicaid. It is up to you to prove the transfer was for another reason. If DCBS determines that there was a prohibited transfer of resources, they may set up a penalty period beginning with the month the transfer was made.

What is Income?

Income is money you get from Social Security, Veteran's pension, Black Lung benefits, Railroad Retirement benefits, pension plans, rental property, investments or wages. Your income must be within Medicaid guidelines to get Medicaid NF services. We consider your income, but do not count your spouse's income. The income limits may vary depending on the number of days you have been in the facility.

You are income eligible if your income is at or below $1,656 or the NF private pay rate. You may be required to pay part of the cost of your care. Patient liability is subsequently determined by considering your income, allowing a deduction of $40 for personal needs, maintenance deductions for family members (including an at home spouse deduction in an amount to bring the at home spouse's income up to $2,267) and deductions for medical expenses and health insurance premiums. The amount left over is what you must pay to the NF for your care.

How can I apply?

You or someone representing you may make a Medicaid application at the DCBS office in the county where you live. Bring proof of social security number, income, resources, life insurance policies or burial reserves, health insurance, and medical bills to the application interview.

Medicaid Provider Enrollme[illegible]g and Accreditation Checklist

Below is a licensing and accreditation checklist for Medical Assistance providers. In addition to the checklist items, providers are required to complete the appropriate forms and return to Unisys. If you do not see your provider type listed, or if no credentials are listed, contact Unisys at (877) 838-5085. NOTE: You may apply in all areas in which you meet the requirements. A separate application is required for each provider type you wish to apply.

Type #	Provider Type	IN STATE					OUT OF STATE					
		CLIA	License or Certif.	Medicare Certif.	Medicare Letter	Medicare Provider #	CLIA	License or Certif.	Medicare Certif.	Medicare Letter	Medicare Provider #	JCAHO
17	Acquired Brain Injury		✓									
43	Adult Day Care	Certification by DMH/MR for each service checked on MAP4100										
27	Adult Targeted		✓									
36	Ambulatory Surg	✓	✓									
70	Audiologist (may apply as group-709)		✓ Annual Renewal		✓		✓	✓ ✓ Annual Renewal		✓		
71	Birthing Center		✓					✓ Annual Renewal				
13	Child Sexual Abuse Clinic	Licensed M.D. and Mental Health professional must be certified by Governor's office										
28	Children Targeted		✓	✓	If QMB Only	If QMB Only		✓ Annual Renewal	✓			
85	Chiropractor (may apply as group-859)		✓	✓		✓		✓ Annual Renewal	✓		✓	
82	Clinic Social Worker (may apply as group-829)		✓	✓								
22	Comm. for Children with Special Health Care Needs											
30	Comm. Mental Health		✓					✓	✓			
91	CORF (comprehensive outpatient rehabilitation facility)			✓	✓	✓			✓			
60	Dental (may apply as group-61)	Specialty license for General Dentist, Oral Surgeon, Pediatric Dentist, Orthodontist, Prosthodontist	✓					✓ Specialty license for General Dentist, Oral Surgeon, Pediatric Dentist, Orthodontist, Prosthodontist				
23	Department Social Services											
39	Dialysis & Renal Dialysis		✓		✓			✓ Annual Renewal		✓		
0	DME (durable medical equip.)	Copy of Pharmacy Permit if Affiliated with Pharmacy				✓					✓	
0	EPSDT		✓ Professional					✓ Annual Renewal		✓		
ype #	Provider Type	CLIA	License or	Medicare	Medicare	Medicare	CLIA	License or	Medicare	Medicare	Medicare	JCAHO

Type #	Provider Type	CLIA	License or Certif.	Medicare Certif.	Medicare Letter	Medicare Provider #	CLIA	License or Certif.	Medicare Certif.	Medicare Letter	Medicare Provider #	JCAHO
43	EPS[illegible]ecial		Certif. ✓ Professional	Certif.	Letter	ovider #		Certif. ✓ Annual Renewal	Certif.	Letter		
32	[illegible]y Planning		✓					✓				
27	First Steps											
15	HANDS											
50	Hearing (may apply as group-509)		✓ Annual Renewal					✓ Annual Renewal				
42	Home & Community Based Waiver		✓									
46	Home Care Wavier		Certification by Office of Aging Services									
34	Home Health	✓ if lab on site	✓		✓			✓ Ky License Reqd.				
44	Hospice		✓					✓ KY License Reqd.				
01	Hospital	✓	✓	✓ or JCAHO, Type 1				Must participate in own state's Medicare or Medicaid				
11	ICF/MR/DD		✓	✓	✓							
37	Independent Lab		✓				✓	✓ Pathologist				
02	Mental Hospital	✓	✓	✓ if serving patients 65+								
41	Model Waiver II							Approved by DMS				
74	Nurse Anet (CRNA) (may apply as group-749)		✓									
78	Nurse Practitioner (ARNP) (may apply as group-789)		✓ ARNP					✓ Annual Renewal				
12	Nursing Facility		✓	✓	✓			✓ ARNP Annual Renewal				
38	Occupational Therapy (may apply as group-879)		✓	✓	✓	✓						
52	Optician (may apply as group-528)		✓ Annual Renewal					Approved by DMS				
7	Optometrist (may apply as group-779)		✓					✓ Annual Renewal	✓			
6	Other Lab X-Ray	✓		✓				✓ Annual Renewal				
							✓			✓		

	Care Waiver											
54		Certification by Office of Aging Serv										
87	Physical Therapy	Operation Permit & Annual Renewals	✓	✓	✓	✓				Operation Permit & Annual Renewals		
64	Physician (MD-Oseapath) (may apply as group-65)	✓								✓ Annual Renewal	✓	
95	Physician Assistant (may apply as group-959)	Specialty License if applicable								✓ Annual Renewal		
80	Podiatrist	✓	✓	✓	✓	✓				Specialty License if applicable		
20	Preventive Care	✓								✓ Annual Renewal	✓	✓
31	Primary Care	Certification for supplied services										
04	PRTF (psychiatric residential)	✓ If Lab	✓	✓								
89	Psychologist (may apply as group-899)	✓	✓ & JCAHO							✓	✓	
35	Rural Health		✓	✓	✓	✓				Approved by DMS		
33	SCL	✓	✓		✓					✓ Annual Renewal	✓	
21	School Based									✓		✓
55	Transportation (emergency)	Certification by Dept. Mental Health Mental Retardation										
56	Transportation (non-emergency)	Dept. of Ed Certification Letter	✓ Annual Renewal							✓ Annual Renewal		
			✓ Annual Renewal							✓ Annual Renewal		

(Rev. (1/00)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT ADDENDUM I

FACILITY NAME: _____

FACILITY ADDRESS: _____

PROVIDER NUMBER: _____

Participation Requirement: Each nursing facility agrees to comply with the pre-admission screening and annual resident review requirement specified in Section 1919 of the Social Security Act, effective with regard to admissions and resident stays occurring on or after January 1, 1989.

PROVIDER

BY: _____
Signature of Authorized Official

Name: _____

Title: _____

Date: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES.

BY: _____
Signature of Authorized Official

Name: _____

Title: _____

Date: _____

MAP-730
(Rev. 6/99)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT ADDENDUM II
FOR
LONG TERM FACILITIES
(NF, ICF/MR/DD OR MENTAL HOSPITAL)
HOME- AND COMMUNITY-BASED WAIVER SERVICES
PROVIDERS FOR:
(HCB, SCL, MODEL WAIVER II,
ACQUIRED BRAIN INJURY, ETC.)

AGENCY\FACILITY NAME: (1) _____

ADDRESS: (2) _____

_____

PROVIDER NUMBER: (3) _____

PARTICIPATION REQUIREMENT:

As a result of the Medicare Catastrophic Coverage Act of 1988, each facility/ agency providing long term care services agrees to advise all new admissions of resource assessments to assist with financial planning performed by the Department for Community Based Services through a contractual arrangement with the Department for Medicaid Services. This requirement is a Condition of Participation in the Kentucky Medicaid Program in accordance with 907 KAR 1:672 and is effective with new admissions on and after September 30, 1989.

PROVIDER

BY: (4) _____
SIGNATURE OF AUTHORIZED OFFICIAL

NAME: (5) _____

TITLE: (6) _____

DATE: (7) _____

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

BY: (8) _____
SIGNATURE OF AUTHORIZED OFFICIAL

NAME: (9) _____

TITLE: (10) _____

DATE: (11) _____

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

_____
(Date)

MEMORANDUM

TO: Local Office
Department for Community Based Services
Cabinet for Families & Children

FROM: _____ Provider #: _____
(Facility/Waiver Agency)

SUBJECT: _____
(Recipient Name) (Social Security/Medicaid Number)

_____
(Previous Address)

_____
(Responsible Relative's Name & Address)

This is to notify you that the above-referenced recipient

☐ was admitted to this facility/waiver agency _____
(Date)
is in Title _____ Payment Status, and was placed in a
(XVIII or XIX)

☐ NF bed ☐ ICF/MR/DD bed ☐ MH bed ☐ EPSDT Bed

☐ Home & Community Based Waiver Service ☐ SCL Waiver Service and/or

☐ was discharged from this facility/waiver agency on _____
(Date)
and went to _____,
(Home Address/Name & Address of New Facility/Waiver Agency)
and/or expired on _____.
(Date)

☐ was re-instated to Home & Community Based or SCL waiver services within 60 days of the NF admission. _____
(Date Re-Instated)

For Home & Community Based waiver Clients only – last date service was provided _____.
(Date)

_____
(Signature)

MAP-24 (Rev. 02/2001)

MAP-552 – NOTICE OF AVAILABLE INCOME FOR LONG TERM CARE

MAP-552p
(5/98)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR SOCIAL INSURANCE

NOTICE OF AVAILABILITY OF INCOME FOR LONG TERM CARE/WAIVER AGENCY/HOSPICE

AID NUMBER:_____ ( ) CORRECTION
( ) INITIAL
( ) CHANGE

PROGRAM: _____

CLIENT'S NAME:_____ DATE OF BIRTH:_____

PROVIDER NUMBER:_____

ADMISSION DATE:_____ DISCHARGE DATE:_____ DEATH DATE:_____

LEVEL OF CARE_____ LTC INELIGIBLE DATE:_____

FAMILY STATUS:_____ SPOUSE STATUS:_____

INCOME COMPUTATION:

UNEARNED INCOME SOURCE	AMOUNT
RSDI	$_____
SSI	$_____
RR	$_____
VA	$_____
STATE SUPPLEMENTATION	$_____
OTHER	$_____
SUB-TOTAL UNEARNED INC.	$_____

ARNED INCOME	AMOUNT
WAGES	$_____
EARNED INC. DEDUCTION	$_____
SUB-TOTAL EARNED INC.	$_____
TOTAL INCOME	$_____

DEDUCTIONS	AMOUNT
PERSONAL NEEDS ALLOWANCE	$_____
INCREASED PNA	$_____
SPOUSE/FAMILY MAINT.	$_____
SMI	$_____
HEALTH INS	$_____
INCURRED MEDICAL EXPENSES	$_____
TOTAL DEDUCTIONS	$_____
VA AID AND ATTENDANCE	$_____
THIRD PARTY PAYMENTS	$_____
AVAILABLE INCOME	$_____
AVAILABLE INCOME (ROUNDED)	$_____
AILABLE MONTHLY INCOME	$_____

CASE STATUS

ACTIVE CASE:_____

IF ACTIVE, EFF. MA DATE:_____

IF DISC. EFF. MA DATE:_____

NOTIF. FORM:_____

NOTIF. FORM DATE:_____

EFF. DATE OF CORR:_____

ENDING DATE OF CORR:_____

PRIVATE PAY PATIENT

FROM:_____ THRU_____

EFFECTIVE DATE:_____

ORKER CODE:_____ CASELOAD CODE:_____ UPDATE DATE:_____

Kentucky Medicaid

LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM CERTIFICATION FORM

I. ESTATE RECOVERY

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1993, states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/BI, ICF/MR/DD), home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services.

Recovery will only be made from an estate if there is no surviving spouse, or children under age 21, or children of any age who are blind or disabled.

I certify that I have read and understand the above information.

_____ _____

Signature Date

II. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, BRAIN INJURY WAIVER

A. HCBS - This is to certify that I/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS program as an alternative to NF placement is requested _____; is not requested _____.

_____ _____

Signature Date

B. This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation/ developmental disabilities. Consideration for the waiver program as an alternative to ICF/MR/DD is requested _____; is not requested _____.

_____ _____

Signature Date

C. MODEL WAIVER II - This is to certify that I/legal representative have been informed of the Model Waiver II program. Consideration for the Model Waiver II program as an alternative to NF placement is requested _____; is not requested _____.

_____ _____

Signature Date

D. BRAIN INJURY (BI) WAIVER - This is to certify that I/legal representative have been informed of the BI Waiver Program. Consideration for the BI Waiver Program as an alternative to NF or NF/BI placement is requested _____; is not requested _____.

_____ _____
Signature Date

III. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

_____ _____
Signature Date

IV. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

_____ _____
Signature Date

V. RECIPIENT INFORMATION

Medicaid Recipient's Name: _____

Address of Recipient: _____

_____

Phone: _____

Medicaid Number: _____

Responsible Party/Legal Representative: _____

Address: _____

_____

Phone: _____

Signature and Title of Person Assisting with Completion of Form:

_____

Agency/Facility: _____

Address: _____

MAP-573 (REV. 12/95)

MAIL TO: UNISYS
P.O. Box 2103
Frankfort, KY 40602-2103

KENTUCKY MEDICAID PROGRAM REQUEST FORM FOR DRUGS PRIOR-AUTHORIZED FOR NURSING FACILITY RESIDENTS

MAID Number	Recipient Name
Facility Name	Facility Address
Facility Provider Number	

Admission Date_____ Effective Date_____

This certifies that the above recipient is (is expected to be) in Kentucky Medicaid vendor payment status in a Medicaid certified nursing facility. Prior authorization is requested for the additional drugs that can be prior authorized as a group.

Authorized Representative of Facility _____

This certifies my request that the above named resident be authorized to receive drugs prior authorized for nursing facility residents.

Name of Physician _____ License Number _____

Signature of Physician _____ Date _____

The facility completes the form and obtains the signature of the physician, retains one (1) copy in the resident's records and provides the pharmacy with the remaining two (2) copies. The pharmacy sends the original copy to Unisys. After processing, Unisys will notify the Pharmacy by letter.

Pharmacy Name	Pharmacy Provider Number
Pharmacy Address	
City/State/Zip	

THIS FORM MUST BE COMPLETED FOR EACH ADMISSION

CAUTION: THE ABOVE RESIDENT MUST BE KENTUCKY MEDICAID ELIGIBLE ON THE DATE OF SERVICE VERIFY BY CHECKING THE RESIDENT'S MEDICAID CARD. THIS PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT.

Mailroom use

_____MAP-552 Continuing Income Information not on file

Date: _____

MAP-409
7/98

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
NURSING FACILITY IDENTIFICATION SCREEN (LEVEL I)

Applicant Name - Last, First | Social Security Number | Date of Birth

Applicant's Address | City | State | Zip Code

I. An individual is considered to have mental illness (MI) if he/she meets all of the following requirements regarding diagnosis; level of impairment and duration of illness.

A. **DIAGNOSIS**

The individual has a major mental disorder [as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM-III)] which includes: a schizophrenic, mood, paranoid, panic or other severe anxiety disorder, somatoform disorder, other psychotic disorders; or another mental disorder that may lead to a chronic disability. This does not include a primary diagnosis of dementia, including Alzheimers'disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined above. ___Yes ___No

B. **LEVEL OF IMPAIRMENT**:

The mental disorder resulted in functional limitations in major life activities within the past 3 to 6 months that would be appropriate for the individual's developmental stage. An individual typically has at least one of the following characteristics on a continuing or intermittent basis (check the appropriate boxes):

___ 1. **Interpersonal functioning**. The individual has serious difficulty interacting appropriately and communicating effectively with other individuals, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation;

___ 2. **Concentration, persistence and pace**. The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks with an established time period, makes frequent errors, or requires assistance in the completion of these tasks;

___ 3. **Adaptation to change**. The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

C. **RECENT TREATMENT**: The treatment history indicates that the individual has experienced at least one of the following (check the appropriate box(es)):

___ 1. Psychiatric treatment more intensive than outpatient psychiatric care more than once in the past 2 years (e.g. partial hospitalization or inpatient hospitalization); or

_____

Name of inpatient facility, partial program or other mental health treatment

___ 2. Within the last 2 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

D. Does the applicant meet all of the requirements of having a mental illness listed in Section I. A -C? ___**Yes** ___ **No**

II. Mental Retardation and Related Conditions

An individual is considered to have mental retardation if he/she has a level of retardation (mild, moderate, severe or profound) as described in the American Association of Mental Retardation Manual on Classification in Mental Retardation (1983).

A. The individual has significantly subaverage general intellectual functioning (I.Q. of approximately 70 or below) resulting in, or associated with, concurrent impairments in adaptive behavior and manifested during the development period, before the age of 18. ___ **Yes** ___ **No**

B. Is there a history of mental retardation or developmental disability in the identified past? ___ **Yes** ____**No**

C. Is there any presenting evidence (cognitive or behavior functions) that may indicate the person has mental retardation or a developmental disability? Please List: ___ **Yes** ___ **No**

_____

_____

D. Has the person been referred by an agency that serves persons with mental retardation or developmental disabilities and been deemed eligible for that agency services?___ **Yes** ___ **No**
Please List Agency:_____

E. "Persons with related conditions" means individuals who have a severe, chronic disability that meets **all** of the following conditions:

1. It is attributable to:

   a. Cerebral palsy or epilepsy; or

   b. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for these persons.

2. It is manifested before the person reaches age 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations **in three or more** of the following areas of major life activities:

   a. Self care;

   b. Understanding and the use of language;

   c. Learning;

   d. Mobility;

   e. Self-direction; or

   f. Capacity for independent living.

Examples of diagnoses that may indicate that the individual has a related condition if all the above criteria are met include:
Autism, Blind/Severe Visual Impairment, Cerebral Palsy, Cystic Fibrosis, Deaf/Severe Hearing Impairment, Head Injury, Epilepsy/Seizure Disorder, Multiple Sclerosis, Spina Bifida, Muscular Dystrophy, Orthopedic Impairment, Speech Impairment, Spinal Cord Injury, or Deafness/Blindness.

Does this applicant meet all of the conditions in Section E? ___ **Yes** ___ **No**

III. If responses to the applicable Section I and/or Section II were answered "Yes", do not admit the applicant to the Nursing Facility. The nursing facility staff shall refer the applicant to the Community Mental Health Center for a Level II PASRR. The Level II PASRR determination shall be completed prior to the nursing facility admitting the applicant.

IF RESPONSES TO THE APPLICABLE SECTION I AND/OR SECTION II WERE ANSWERED "NO" AND THERE IS NO FURTHER EVIDENCE TO INDICATE THE POSSIBILITY OF MENTAL ILLNESS, MENTAL RETARDATION, OR OTHER RELATED CONDITION, THE NURSING FACILITY MUST DECIDE WHETHER OR NOT TO ADMIT THE APPLICANT. ADMISSION TO THE FACILITY DOES NOT CONSTITUTE APPROVAL FOR TITLE XIX LEVEL OF CARE.

IV. **Does the applicant meet the Criteria for Exceptional Admission to a Nursing Facility without a Level II PASRR. The applicant may be admitted if one of the following conditions exists (PLEASE NOTE TIME LIMITS):**

A. **Person Is An Exempted Hospital Discharge**

Although identified as an individual with mental illness___, mental retardation___, or other related condition___, an applicant who is not dangerous to self and/or others may be directly admitted for nursing facility services from an acute care hospital **for a period up to 30 days** without a Level II PASRR if such admission is based on a written medically prescribed period of recovery for the conditions requiring hospitalization. An Exempted Hospital Discharge Physician Certification form shall be completed and in the resident's clinical record at the nursing facility.

___ **Yes** ___ **No**

B. **Person Requires Respite Care**

Although identified as an individual with mental illness___, mental retardation___, or other related condition___, an applicant who is not dangerous to self or others may be admitted for Respite Care **for a period up to 14 days** without a Level II PASRR. A Provisional Admission Form shall be completed and in the resident's clinical record at the nursing facility.

____Yes ___No

C. **Person Has A Diagnosis of Delirium**

Although identified as an individual with mental illness___, mental retardation___, or other related condition___, an applicant who is not dangerous to self and/or others may receive nursing facility services **for a period up to 14 days** without a Level II PASRR, if certified by the referring or attending physician to have a diagnosis of delirium. A Provisional Admission Form shall be completed and in the resident's clinical record at the nursing facility.

___Yes ___No

****

ROUTING OF FORM

This form shall be completed by nursing facility personnel prior to admission of the applicant to the nursing facility.

If the individual wishes to apply for Medicaid, application shall be made to the local county DSI office in the usual manner.

The facility is required to call the PRO for the Medicaid level of care determination prior to admission, and a copy of the Level I and, if appropriate, Level II PASRR, shall be faxed to the PRO. Except for the pre-admission screening process, the procedure for approval of nursing facility applicants remains the same.

A COPY OF THIS FORM, AS WELL AS A COPY OF THE LEVEL II PASRR DETERMINATION, IF REQUIRED, **SHALL** BE PLACED IN EACH RESIDENT'S CLINICAL RECORD AT THE FACILITY.

If someone other than the person signing the form provided any of the above history, please list name and telephone number:

_____

I understand that this report may be relied upon for payment of claims from Federal and State funds. Any willful falsification or concealment of a material fact may result in prosecution under Federal and State Laws. I certify that to the best of my knowledge, the foregoing information is true, accurate and complete.

_____ _____ _____ _____

Signature Title Date Telephone Number

Facility Name_____ Medicaid ProviderNumber_____

****

COPY TO: Original - Community Mental Health Center
Second - Medical Records

MAP-4092
07/98

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PREADMISSION SCREENING (PAS)

EXEMPTED HOSPITAL DISCHARGE
PHYSICIAN CERTIFICATION OF NEED
FOR NURSING FACILITY SERVICES

Applicant's
Name_____

Social Security Number_____Date of Birth_____

Name of Nursing Facility Requested_____Date Admitted to NF_____

Nursing Facility Medicaid Provider Number_____

Name of Hospital Discharged From_____Date of Discharge_____

Hospital's Medicaid Provider Number_____

Level I screen triggered mental illness ___Yes
Level I screen triggered mental retardation or related condition ___Yes

Exempted Hospital Discharge: An exempted hospital discharge means:

1. The applicant is being admitted to a nursing facility after receiving acute inpatient care at the hospital; and ___Yes

2. The applicant requires nursing facility care for the condition for which he received care in the hospital; and ___Yes

3. The attending physician, upon signing this document, has certified to the nursing facility that applicant is likely to require less than thirty (30) days nursing facility services. ___Yes

Attending Physician
Signature_____Date_____

Print Attending Physician Name_____

Note: If an individual enters the nursing facility as an exempted hospital discharge and is later found to require more than thirty (30) days of nursing facility care, a Level II PASRR shall be completed within forty (40) calendar days of admission. The nursing facility staff shall refer persons with mental illness, mental retardation or related condition for a Level II PASRR evaluation prior to the end of the exempt thirty (30) days by transmitting a copy of this form to the Community Mental Health/Mental Retardation Center. (This allows ten (10) calendar days for the Level II PASRR to be completed.)

Date Transmitted_____

Signature and Title_____

Print Name and Title_____

Original to Community Mental Health/Mental Retardation Center
Second Copy - Medical Records

MAP-4093
07/98

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PREADMISSION SCREENING (PAS)

PROVISIONAL ADMISSION
TO A NURSING FACILITY

Applicant's
Name_____

Social Security Number_____ Date of Birth_____

Name of Nursing Facility_____

Medicaid Provider Number_____ Phone Number_____

Address_____ FAX Number_____

Date Admitted to NF_____

Level I screen triggered mental illness ___Yes
Level I screen triggered mental retardation or a related condition ___Yes

"Provisional Admission" means an individual who is admitted to a nursing facility for fourteen (14) days or less before a PASRR Level II is required; and

1. The applicant is expected to stay in NF for fourteen (14) days or less; and ___Yes
2. The applicant has been diagnosed with delirium; or ___Yes
3. The applicant is in need of respite for the in-home care giver, and the applicant is expected to return to that in-home care giver upon discharge from the nursing facility. ___Yes

Authorized Nursing Facility
Staff_____ Date_____

NF Applicant Responsible
Party_____

Note: If an individual who is admitted to a NF under the provisional admission is later found to require more than fourteen (14) days of nursing facility services, a Level II PASRR shall be completed within the fourteen day provisional admission. Therefore, nursing facility staff shall refer the individual for a Level II PASRR as soon as it is indicated that the resident requires more than fourteen days of nursing facility services by transmitting a copy of this form to the Community Mental Health/Mental Retardation Center. PASRR evaluators shall complete the Level II PASSR written evaluation report within nine (9) working days from the referral date.

Date Transmitted _____

Signature and Title _____

Print Name and Title_____

Original to Community Mental Health/Mental Retardation Center
Second Copy - Medical Records

MAP-4094
07/98

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

NOTIFICATION OF INTENT TO REFER
FOR LEVEL II PASRR

Individual/Resident Name_____

Social Security Number_____Date of Birth_____

Home Address (if not in facility)_____

Name of Nursing Facility_____

Medicaid Provider Number_____

Facility Address_____Phone
Number_____

Date Admitted to Nursing Facility_____

Responsible Party_____

Address_____Phone
Number_____

Date Level I PASRR
completed_____

This is the written notification to inform the individual and the responsible party that the Level I PASRR indicates a diagnosis of mental illness ___ or mental retardation or a relatead condition ____ (Please check appropriate blank). The individual is being referred to the Community Mental Health/Mental Retardation Center for a Level II PASRR. The Level II PASRR is an evaluation and determination of the need for nursing facility services, and if so, whether specialized services are needed.

Authorized Nursing Facility Staff_____Date_____

Print Authorized Nursing Facility Staff Name_____

Original copy to Individual or responsible party
Second copy - Medical Records
Third copy - Community Mental Health/Mental Retardation Center

MAP-4095
07/98

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

SIGNIFICANT CHANGE IN CONDITION REFERRAL

Nursing facilities shall notify the Community Mental Health/Mental Retardation Centers promptly after a significant change in the physical or mental condition of a resident who is mentally ill, mentally retarded or has a related condition, including residents who are newly diagnosed.

"Significant change" means that the individual's condition has immediate treatment needs requiring a comprehensive reassessment and material change in plan of care as established by the Long Term Care Resident Assessment Instrument User's Manual. If a significant change in the individual's condition occurs, the nursing facility shall transmit a copy of the completed form to the Community Mental Health/Mental Retardation Center within twenty-one (21) days and the Level II PASRR shall be completed within nine (9) working days.

Name of Nursing Facility_____

Address_____Medicaid Provider #_____

Resident's Name_____Social Security #_____

Date of Birth_____Date of Significant Change_____

Referral Date For Level II PASRR_____

MDS Coordinator (Print Name)_____

MDS Coordinator Signature_____

Phone Number_____

Original to Community Mental Health/Mental Retardation Center
Second Copy - Medical Records

CONTACT REGIONS FOR PASRR REFERRALS

REGION 1
Western KY MH/MR Board
P.O. Box 7287
Paducah, KY 42002
Tel: 502/442-7121

REGION 2
Pennyroyal MH/MR Board
735 North Drive
Hopkinsville, KY 42240
Tel: 502/886-5163

REGION 3
River Valley Behavioral
P.O. Box 1637
Owensboro, KY 42302
Tel: 502/684-0696

REGION 4
LifeSkills, Inc.
523 E. 12th Street
Bowing Green, KY 42101
Tel: 502/842-4887

REGION 5
Communicare, Inc.
1311 N.Dixie Avenue
Elizabethtown, kY 42701
Tel: 502/769-5301

REGION 6
Seven Counties Services,
Inc. 929 S. Third Street
Louisville, KY 40203
Tel: 502/585-2008

REGION 7
Northern Kentucky MH/MR
1201 S. Ft. Thomas Avenue
Fort Thomas, KY 41075
Tel: 606/781-5586

REGION 8
Comprehend, Inc.
611 Forest Avenue
Maysville, KY 41056
Tel: 606/564-4016

REGION 9
Pathways, Inc.
P.O. Box 790
Ashland, KY 41105-0790
Tel: 606/324-1141

REGION 10
Mountain MH/MR Board
150 S. Front Street
Prestonburg, KY 41653
Tel: 606/886-8572

REGION 11
KY. River Community Care
P.O. Box 587
Hyden, KY 41749
Tel: 606/678-4215

REGION 12
Area A
Cumberland River MH/MR
P.O. Box 568
Corbin, KY 40701
Tel: 606/528-7010

Area B
Cumberland River MH/MR
Mounted Route
Harlan, KY. 40831
Tel: 606/337-6137

REGION 13
ADANTA
103 Reed Street
Colimbia, KY 42748
Tel: 502/384-5351

REGION 14
Bluegrass MH/MR Board
191 Doctors Drive
Frankfort, KY 40601
Tel: 502/223-1606